HERTFORDSHIRE COUNTY COUNCIL

health welfare and school health services

1970

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County Hall,
Hertford,
October, 1971

To the Chairmen and Members of the Health, Social Services, and Education Committees.

Ladies and Gentlemen,

This is the last annual report I shall be presenting on the health, welfare, and school health services in Hertfordshire for as from April, 1971, the combined Health and Welfare Department ceased to exist, and two separately administered departments became responsible for the local authority's health and social services. Not unnaturally, the development of an independent social services department had, and has, its devotees but not all members of the combined staff shared the same enthusiasm. Concern about future roles were not infrequently expressed and the unavoidable halt in progress in the field of combined health and welfare administration produced a stultifying effect on the department as a whole. This was inevitable and understood. Attendance of staff at meetings to discuss and plan the future pattern of administration of social services caused some disruption in the routine work of the department and added substantially to the work load carried by the senior officers. I am particularly grateful to them for maintaining a high standard of work during the year but in addition for finding the time to prepare the various sections of this report.

I am, Ladies and Gentlemen,

Your obedient servant,

G. W. Knight,
County Medical Officer.

HEALTH AND WELFARE COMMITTEE.

Chairman.

County Councillor Mr. H. L. Morbey.

Vice-Chairman.

County Councillor Mr. A. C. Vincent.

Chairmen of Sub-Committees.

Health Services :	County Councillor Mr. A. C. Vincent.
Social Welfare Services :	County Alderman Miss J. B. Campbell, M.B.E.
General Purposes :	County Councillor Mr. H. L. Morbey.
Ambulance :	County Councillor Mr. M. Newling Ward.

EDUCATION COMMITTEE.

Chairman.

County Alderman Mr. F. Bramston Austin.

Vice-Chairman.

County Alderman Mr. A. D. Sheridan.

Special Services Sub-Committee.

Chairman.

County Councillor Miss L. A. M. Lloyd-Taylor.

Staff as at 1st January, 1971.

County Medical Officer, G. W. Knight, M.D., D.P.H.
Deputy County Medical Officer, W. Stewart, M.B., Ch.B., D.P.H.
Second Deputy County Medical Officer, F. Seymour, M.B., Ch.B., D.P.H.

Administration of Services.

Social and Welfare Services :	County Welfare Officer, R. S. J. Potter, A.I.S.W. (Resigned 30.9.70).
Health Services :	Senior Administrative Officer, W. A. Treharne, A.C.I.S.
Management :	Senior Administrative Officer, H. J. P. Page, A.I.M.T.A.

Principal Dental Officer.

A. H. Millett, L.D.S., R.C.S.

Consultant Psychiatrist (part-time).

J. L. McClure, M.B., B.S., D.P.M., M.R.C.P.

Divisional Medical Officers.

Dacorum :	R. S. Hynd, M.B., Ch.B., D.P.H., Town Hall, Marlowes, Hemel Hempstead.
East Herts :	J. V. Earle, M.A., M.B., B.Ch., D.P.H., D.I.H., Council Offices, High Street, Hoddesdon.
North Herts :	J. D. Hall, M.R.C.S., L.R.C.P., D.P.H., Bedford Road, Hitchin.
St. Albans :	W. Norman-Taylor, M.D., D.P.H., D.I.H., Bleak House, Catherine Street, St. Albans.
South-West Herts :	A. Shaw, M.B., B.S., D.P.H., Town Hall, Watford.
Welwyn :	G. R. Taylor, M.B., B.S., D.P.H., "Gooseacre," Cole Green Lane Welwyn Garden City.

Medical Officers (Salaried).

M. M. E. Barnard, M.B., B.S., D.P.H.
D. M. Batty, M.B., Ch.B.
J. C. Bond, M.B., Ch.B.
J. C. Brown, M.B., Ch.B.
I. R. Clarke, M.B., Ch.B., D.R.C.O.G., D.P.H.
A. Derola, M.B., Ch.B.
C. H. Fourcin, L.A.H.
M. Fox, M.B., Ch.B., C.P.H.
J. S. Gardiner, B.Sc., M.D.
M. E. Gill, M.B., B.S.
J. E. Hughes, M.B., B.S., D.P.H.
E. M. Jennings, M.B., Ch.B., D.R.C.O.G.
J. A. Leigh, M.B., Ch.B.
J. E. Leveson, M.B., B.S.
N. MacRae, M.B., Ch.B., D.P.H.
D. J. Marsden, M.B., Ch.B., D.C.H.
B. S. M. Marshall, M.B., Ch.B.
P. L. Martin, M.B., B.S., D.R.C.O.G., D.P.H.
M. O'Donovan, M.B., B.Ch., B.A.O.
J. S. Paulley, M.B., Ch.B.
J. M. Ponsford, L.R.C.P. & S., D.R.C.O.G., D.P.H.
J. Poole, M.B., Ch.B., D.C.H.
E. P. Rigby, M.B.E., M.B., B.S., D.P.H., D.T.M.&H.
J. A. M. M. Stevenson, M.R.C.S., L.R.C.P., D.P.H.
M. E. Wehner, B.A., M.B., B.Chir., D.C.H.
J. Whalley, M.B., Ch.B., D.C.H.
A. Wilkes, M.B., B.S., D.P.H.
F. E. Woodthorpe, M.R.C.S., L.R.C.P.

There are in addition a number of fee-paid part-time medical officers.

Chest Physicians.

J. H. Angel, M.D., M.R.C.P.
T. A. W. Edwards, B.A., M.B., B.Ch., M.R.C.P.
A. G. Hounslow, M.D.
E. Rhys Jones, M.B., B.Sc., M.R.C.P.
V. U. Lutwyche, M.A., M.D., M.R.C.P., D.C.H.
N. MacDonald, M.B., Ch.B., F.R.C.P.
A. Pines, M.A., M.D., M.R.C.P.
J. C. Roberts, M.D., M.R.C.P.
P. W. Roe, B.A., B.M., B.Ch.

County Nursing Officer and Day Nurseries Supervisor.

V. M. King, S.R.N., S.C.M., H.V., Q.N.

Deputy County Nursing Officer.

D. Carter, S.R.N., S.C.M., H.V., Q.N.

Second Deputy County Nursing Officer.

S. H. Kestin, S.R.N., S.C.M., H.V., Q.N.

Divisional Nursing Officers.

Dacorum :	V. L. Turner, S.R.N., S.C.M., H.V., Q.N.
East Herts :	M. E. James, S.R.N., S.C.M., H.V., Q.N.
North Herts :	B. L. Shippam, S.R.N., S.C.M., H.V., Q.N.
St. Albans :	M. J. Elliott, S.R.N., S.C.M., H.V., Q.N.
South-West Herts :	D. D. Cantrill, S.R.N., S.C.M., H.V., Q.N.
Welwyn :	D. E. Reay, S.R.N., S.C.M., H.V., Q.N.

County Health Inspector.

J. L. Stringer, F.I.P.H.E., M.R.S.H., F.A.P.H.I.,

Deputy County Health Inspector.

W. S. Biggins, M.A.P.H.I., A.M.Inst.P.C.

Statistician.

V. A. Dickinson, B.Sc.

Deputy County Welfare Officer.

B. A. Creed, A.I.S.W.

Social Work Supervisor.

I. Page, Diploma in Social Science, Certificate Applied Social Studies.

Senior Casework Adviser.

Vacant post.

Divisional Social Workers.

Dacorum : F. Guest, S.R.N., R.M.N., National Certificate in Social Work.
East Herts : H. M. Watson, Diploma in Social Science, P.S.W.
North Herts : N. A. Parker, Certificate in Social Work.
St. Albans : A. G. Gillespie, Certificate in Social Work.
South-West : M. Keenleyside, B.A.(Hons.), Social Science Certificate.
Welwyn : A. Jones, M.A., Diploma Soc.Admin., P.S.W.

Home Help Organizer.

C. M. Webb, M.I.H.H.O., Certificate in Home Help Organization.

Chiropodists.

S. Devine, S.R.Ch.
M. M. Williams, M.Ch.S.

Divisional Dental Officers.

L. M. J. Ewart, L.D.S.
P. C. Perkins, L.D.S., R.C.S., B.D.S.
D. Caplan, L.D.S., R.C.S., B.D.S.
D. H. Silver, L.D.S.
R. J. Smee, L.D.S., R.C.S., D.D.P.H.
P. M. Tanner, L.D.S., R.C.S.

Orthodontists.

J. F. Crawford, L.D.S., D.Orth., R.C.S.
S. J. Zaufal, B.D.S., D.Orth., R.C.S.

Dental Officers (Salaried).

D. M. Bain, L.D.S., R.C.S.
R. L. Kenyon, L.D.S., R.C.S., B.D.S.
J. M. McCaffrey, L.D.S., R.C.S.
E. H. Musgrove, L.D.S., R.C.S.
B. W. P. Roberts, L.D.S., R.C.S.
P. M. Schulte, B.D.S.
G. A. Smee, L.D.S., R.C.S.
M. J. Wicks, L.D.S., R.C.S., B.D.S.
J. A. Winwood, L.D.S., R.C.S.

In addition, 28 part-time dental officers were employed.

Dental Auxiliaries.

C. M. Foley.
V. E. Howes.
F. C. Denny.
J. E. Dickenson.
S. C. Paterson.
J. L. Legood.
M. Walker.

Dental Surgery Assistants.

19 whole-time and 40 part-time were employed.

Senior Speech Therapist.

Leonard A. Willmore, F.C.S.T.

Speech Therapists.

22 Speech Therapists were employed (equivalent 15·4 whole time).

Orthoptists.

8 Orthoptists were employed (equivalent 3·4 whole time).

Audiometricians.

3 Audiometricians were employed (equivalent 2·5 whole time).

MEDICAL OFFICERS OF HEALTH AND PUBLIC HEALTH INSPECTORS OF COUNTY DISTRICTS.

(As at 1.1.1971.)

Division.	*District M.O.H.*	*County District.*	*Public Health Inspector*
Dacorum	Dr. R. S. Hynd **(Divisional M.O.).**	Hemel Hempstead M.B.	Mr. A. C. Horne
		Berkhamsted U.D.	Mr. R. C. Sweet
		Tring U.D.	Mr. T. William Jones
		Berkhamsted R.D.	Mr. R. J. Blandamer
		Hemel Hempstead R.D	Mr. R. H. T. Chappell
East Herts	Dr. I. R. Clarke	Bishop's Stortford U.D.	Mr. A. L. Good
	Dr. J. V. Earle **(Divisional M.O.).**	Cheshunt U.D.	Mr. J. L. Billings
		Hertford M.B.	Mr. B. W. Peck
		Hoddesdon U.D.	Mr. W. D. Scott
		Sawbridgeworth U.D.	Mr C. A. Ford
		Ware U.D.	Mr. C. J. Lucas
		Braughing R.D.	Mr. P. E. L. Reed
		Ware R.D.	Mr. A. D. G. Goold
	*Dr. P. de Bec Turtle	Hertford R.D.	Mr. H. E. Gilby
North Herts	Dr. J. D. Hall **(Divisional M.O.).**	Baldock U.D.	Mr. B. G. Willis
		Hitchin U.D.	Mr. N. Holt
		Letchworth U.D.	Mr. R. H. Mann
		Royston U.D.	Mr. D. G. Lord
		Stevenage U.D.	Mr. R. V. Lamey
		Hitchin R.D.	Mr. W. M. Matthews
St. Albans	Dr. W. Norman-Taylor **(Divisional M.O.).** Dr. P. B. O'Reilly **(Deputy Divisional M.O.).**	City of St. Albans	Mr. R. E. C. Goddard
		Harpenden U.D.	Mr. J. Snowden
		St. Albans R.D.	Mr. L. Lowe
		Elstree R.D.	Mr. G. Male
South-West Herts	Dr. A. Shaw **(Divisional M.O.).** Dr. F. Barasi **(Deputy Divisional M.O.)**	Bushey U.D.	Mr. A. C. F. Gisborne
		Chorleywood U.D.	Mr. W. E. Hands
		Rickmansworth U.D.	Mr. F. W. Keene
		Watford M.B	Mr. K. H. Marsden
		Watford R.D.	Mr. F. Reeve
Welwyn	Dr. G. R. Taylor **(Divisional M.O.).**	Welwyn Garden City U.D.	Mr. L. Gardiner
		Hatfield R.D.	Mr. C. A. Bailey
		Welwyn R.D.	D. N. Sibley
	*Dr. M. I. Outram	Potters Bar U.D..	Mr. J. H. Rooley

Where indicated by an asterisk, the officers named serve County District Councils and are not on the staff of the County Council. This list is included in the Report for the information of those interested in the staffing of the Health Services in the County as a whole.

PART I—HEALTH SERVICES.

Vital Statistics.

The Registrar General's estimate of population for mid 1970 shows an increase of 8,610 over the mid-1969 estimate. Most of the increase occurred in the North and East Divisions. The population of Hertfordshire is still the eighth highest of the forty-five administrative counties in England.

The population is spread between the six Health and Welfare divisions as follows :—

Table 1.—County and Divisional Populations, 1970.

Division	Population (mid-year estimate)
East	165,670
North	161,560
St. Albans	156,680
South-West	195,370
Welwyn	120,200
Dacorum	112,520
County	912,000

Table 2.—Principal Vital Statistics—Attributed to Hertfordshire by Registrar General.

	1970.	*1969.*
Live births :		
Number	14,269	14,300
Rate per 1,000 population	15·6	15·8
Illegitimate live births (per cent of total live births)	5·6	6·0
Stillbirths :		
Number	155	157
Rate per 1,000 total live and still births	10·7	10·9
Total live and still births	14,424	14,457
Infant deaths (deaths under one year)	212	202
Infant mortality rates :		
Total infant deaths per 1,000 total live births	14·9	14·1
Legitimate infant deaths per 1,000 legitimate live births	14·1	13·6
Illegitimate infant deaths per 1,000 illegitimate live births	27·3	22·2
Neo-natal mortality rate (deaths under four weeks per 1,000 total live births)	10·7	10·0
Early neo-natal mortality rate (deaths under one week per 1,000 total live births)	9·3	9·0
Perinatal mortality rate (still births and deaths under one week combined per 1,000 total live and still births)	20·0	20·0
Maternal mortality (including abortion) :		
Number of deaths	1	2
Rate per 1,000 total live and still births	0·06	0·14
Epidemic death rate per 1,000 population	0·04	0·06
Tuberculosis death rate per 1,000 population	0·02	0·03
Respiratory diseases death rate per 1,000 population	1·33	1·27
Cerebrovascular disease death rate per 1,000 population	1·36	1·32
Cancer death rate per 1,000 population	2·02	1·95
Heart disease death rate per 1,000 population	2·91	2·17

Table 3.—Causes of Deaths in Hertfordshire, 1970.

	Age Group																							
	Under 4 wks.		4 wks.-1 yr.		1 –		5 –		15 –		25 –		35 –		45 –		55 –		65 –		75 and over		Totals	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Bacillary dysentery and amoebiasis	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	1
Enteritis and other diarrhoeal diseases	—	—	4	1	—	1	—	—	—	—	—	1	—	—	—	—	1	—	—	—	—	3	5	6
Tuberculosis, respiratory	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1	1	2	1	2	—	—	—	5	3
Tuberculosis, respiratory, late effects of	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1	5	2	1	1	7	4
Tuberculosis, other, incl. late effects	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1	—	—	—	2	—
Meningococcal infection	—	—	1	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1
Measles	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—
Syphilis and its sequelae	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	1	—	—	1	3	1
All other infective and parasitic diseases	—	2	—	—	—	—	—	—	1	—	1	—	1	—	—	—	1	1	1	2	—	1	5	6
Malignant neoplasm, buccal cavity, etc.	—	—	—	—	—	—	—	—	—	—	—	—	3	—	—	1	4	2	1	5	2	4	10	12
Malignant neoplasm, oesophagus	—	—	—	—	—	—	—	—	—	—	—	—	3	—	1	1	5	4	11	5	6	7	26	17
Malignant neoplasm, stomach	—	—	—	—	—	—	—	—	—	—	—	2	3	1	11	7	37	13	32	25	33	48	116	96
Malignant neoplasm, intestine	—	—	—	—	—	—	—	—	—	1	1	1	1	5	11	16	26	23	35	31	27	55	101	132
Malignant neoplasm, larynx	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	3	—	3	—	9	—
Malignant neoplasm, lung, bronchus	—	—	—	—	—	—	—	—	1	—	—	—	4	2	40	10	151	25	136	24	80	23	412	84
Malignant neoplasm, breast	—	—	—	—	—	—	—	—	—	—	—	—	—	16	—	37	1	53	1	43	—	35	2	184
Malignant neoplasm, uterus	—	—	—	—	—	—	—	—	—	—	—	1	—	5	—	6	—	9	—	10	—	11	—	42
Malignant neoplasm, prostate	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	12	—	19	—	36	—	69	—
Leukaemia	—	—	—	—	2	2	2	1	2	1	2	1	3	3	4	2	5	7	7	2	8	15	35	34
Other malignant neoplasms	—	—	—	—	—	1	3	2	6	1	7	6	10	9	28	32	66	52	67	80	33	92	220	277
Benign neoplasms and neoplasms of unspecified nature	—	—	—	—	—	—	1	—	—	—	—	1	1	—	3	1	5	1	2	—	2	—	14	3
Diabetes mellitus	—	—	—	—	—	—	—	—	1	—	—	—	4	—	—	—	6	9	7	13	11	20	29	42
Avitaminoses and other nutritional deficiency	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	3	—	2	—	6
Other endocrine, nutritional and metabolic diseases	—	2	—	—	—	1	1	1	—	—	—	—	—	—	2	3	3	6	2	4	1	10	12	27
Anaemias	—	—	—	—	1	—	—	3	3	—	—	—	—	—	—	—	—	1	2	4	7	8	10	16
Other diseases of blood and blood-forming organs	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	2	2	3
Mental disorders	—	—	—	—	—	—	1	—	2	1	—	—	—	—	2	—	—	1	1	2	4	11	10	15
Meningitis	—	—	—	—	2	1	1	—	—	—	—	—	1	—	—	—	—	—	—	—	—	1	4	2
Multiple sclerosis	—	—	—	—	—	—	—	—	—	—	—	—	1	1	2	2	2	—	—	3	—	—	5	6
Other diseases of nervous system and sense organs	—	—	1	—	1	2	—	2	1	1	1	1	2	1	2	1	6	7	11	8	13	19	38	42
Chronic rheumatic heart disease	—	—	—	—	—	—	—	—	—	—	—	—	3	3	3	6	13	9	9	21	10	32	38	71

	Age Group																							
	Under 4 wks.		4 wks.-1 yr.		1 –		5 –		15 –		25 –		35 –		45 –		55 –		65 –		75 and over		Totals	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Hypertensive disease	—	—	—	—	—	—	—	—	—	—	—	—	1	—	8	—	13	9	12	14	21	66	55	89
Ischaemic heart disease	—	—	—	—	—	—	—	—	2	—	3	—	37	5	142	22	305	66	387	188	304	507	1,180	788
Other forms of heart disease	—	—	1	—	—	1	1	1	1	—	1	1	3	1	2	4	13	9	33	41	96	223	151	281
Cerebrovascular disease	—	—	—	—	—	—	—	—	2	3	2	2	5	8	26	25	66	51	134	159	243	519	478	767
Other diseases of the circulatory system	—	—	—	—	—	—	—	—	1	2	2	—	3	—	4	5	26	13	50	38	65	122	151	180
Influenza	—	—	1	—	1	1	—	—	—	—	—	—	—	1	1	3	3	5	17	18	11	23	34	51
Pneumonia	2	4	7	3	2	—	2	1	2	2	6	1	6	6	5	7	26	26	66	58	162	295	286	403
Bronchitis, emphysema	—	—	—	2	1	—	—	—	—	1	—	—	1	1	10	4	39	12	117	27	136	71	304	118
Asthma	—	—	—	—	—	—	1	1	—	—	2	1	1	1	—	1	5	1	1	—	—	1	10	6
Other diseases of the respiratory system	—	—	8	3	4	—	1	1	1	1	—	1	—	1	1	3	10	4	11	7	11	21	47	42
Peptic ulcer	—	—	—	—	—	—	—	—	—	—	—	1	1	—	2	—	5	2	8	3	18	8	34	14
Appendicitis	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	1	—	—	1	—	—	1	2
Intestinal obstruction and hernia	2	—	2	1	1	—	—	—	—	—	1	2	1	2	1	1	1	2	5	4	4	14	18	26
Cirrhosis of liver	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	6	3	1	4	1	1	9	8
Other diseases of the digestive system	—	—	—	—	—	—	—	1	1	1	—	—	1	3	4	3	7	8	10	9	11	23	34	48
Nephritis and nephrosis	—	—	—	—	—	—	—	—	—	1	—	—	1	1	5	1	5	1	2	9	8	16	21	29
Hyperplasia of prostate	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	2	—	14	—	18	—
Other diseases of the genito-urinary system	—	—	—	—	—	—	—	—	1	1	—	1	2	—	—	1	2	4	7	12	16	29	28	48
Complications of pregnancy	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	1
Diseases of the skin and subcutaneous tissue	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1	1	—	1	—	4	1	7
Disease of the musculo-skeletal system	—	—	—	—	—	—	—	—	—	1	—	—	—	1	2	2	3	2	1	7	6	8	12	21
Congenital anomalies	21	20	5	8	3	4	2	1	2	—	1	1	1	—	1	—	—	2	2	3	—	2	38	41
Birth injury, difficult labour, etc.	25	22	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	25	22
Other causes of perinatal mortality	31	21	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	31	21
Symptoms and ill-defined conditions	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	17	47	18	48
Motor vehicle accidents	—	—	—	—	1	—	10	—	32	5	7	4	6	2	8	5	8	5	8	4	4	7	84	32
All other accidents	—	—	6	4	7	2	3	—	9	3	5	1	9	1	3	7	12	4	9	13	18	53	81	88
Suicide and self-inflicted injuries	—	—	—	—	—	—	—	—	4	2	5	3	1	6	5	4	6	5	3	10	1	2	25	32
All other external causes	—	—	1	—	1	—	—	—	—	3	4	—	1	1	2	1	4	—	1	5	1	3	15	13
Totals	81	72	37	22	29	16	29	16	75	32	51	34	121	89	347	227	920	461	1,245	923	1,446	2,466	4,379	4,358

MIDWIFERY SERVICE.

TABLE 4.—NOTIFIED BIRTHS AND STILLBIRTHS OF HERTFORDSHIRE RESIDENTS.

	1970.	*1969.*	*1968.*
Total births and stillbirths . . .	14,397	14,322	14,475
In hospitals	11,256	10,742	10,631
At home	3,141	3,580	3,831
Percentage of domiciliary births . .	21·8	25·0	26·4

TABLE 5.—PATIENTS DISCHARGED FROM HOSPITAL TO DISTRICT MIDWIFE CARE.

	Reports made on home conditions.	*Hospital confinements.*	*Early discharge from hospital.*	*Total visits by domiciliary midwives.*
1966 . . .	2,530	8,456	5,069	24,411
1967 . . .	2,760	8,655	5,151	24,493
1968 . . .	3,300	10,631	4,975	22,441
1969 . . .	2,933	10,742	4,948	22,699
1970 . . .	3,947	11,256	5,049	26,828

The number of women confined in hospital has increased each year and in 1970, there were 11,256 births as against 3,141 delivered at home, making a total of 21·8 per cent domiciliary confinements. The highest domiciliary rate was in the Stevenage, Letchworth, Hertford, and Cheshunt areas.

In 1970, 4,693 women were discharged within 48 hours of delivery, and 5,049 before the 10th day of the puerperium. This has meant that only 1,514 out of a total 11,256 have remained in hospital for ten days or longer.

The proposed future integrated health services had started to become effective in the midwifery field, as domiciliary midwives have been able to deliver in hospital those patients booked for early discharge and then to continue the patients care when discharged to their homes. These arrangements have been made in conjunction with Shrodells Maternity Hospital, Watford, Bushey Maternity Hospital, and Harpenden Cottage Hospital. Arrangements with the other maternity hospitals have been under discussion.

Although the lying in period is still of ten days duration, the practice has arisen whereby patients may be discharged home early after delivery if the home circumstances are favourable for their reception. Their care is continued by the domiciliary midwife together with the general medical practitioner.

Midwives Refresher Courses.

A course for midwives was organized in the county for methods of teaching relaxation and exercises for ante-natal patients. Forty-two midwives attended this three-day study. In addition thirty-six midwives attended the compulsory five yearly courses approved by the Central Midwives Board, organized by other bodies outside the county.

Ante-Natal Instruction.

All the domiciliary midwives have been trained in methods of teaching relaxation exercises, and in preparing expectant mothers for their confinements. In the year, 1,852 patients who were booked for hospital made 6,199 attendances and of the 439 booked for home delivery made 1,480 attendances.

All these patients attended classes organized by the domiciliary midwives.

Maternal Mortality.

There was one maternal death out of a total 14,424 births in the County. The rate per 1,000 live births being 0·06 compared to 0·18 for England and Wales.

Phenylketonuria.

All domiciliary midwives carry out the Guthrie Test on babies at about the 7th day after birth, and in this area all the blood test cards are sent to Great Ormond Street Hospital. In 1970, 1 baby was found to be suffering from phenylketonuria which could cause irrepairable brain damage if not diagnosed and treated at an early stage in life. The baby is now under treatment.

Ambulance Service—Emergency Childbirth.

The ambulance service conveyed 3,290 maternity patients. 6 births took place in the ambulances, and a midwife was present except on 1 occasion.

Some women call the ambulance too late, and for this reason 38 women were delivered in their own homes before or after the arrival of the ambulance ; 2 infants were born prematurely. Complications were present in 3 births ; 1 of these being a still birth.

Staff Numbers and Training of Pupil Midwives.

The number of midwives employed was 144 which represented a whole time equivalent of 71·5 ; 46 were engaged in the training of pupil midwives drawn from 4 hospitals within the County and 3 outside. During the year, 138 pupils were accepted for domiciliary training and of this number 40 were from the maternity wing of Watford General Hospital.

Since the modification of midwifery training the number of domiciliary deliveries has been reduced for pupil midwives, organized courses in community care for these students have been arranged by the nursing officers each quarter. each quarter.

Cervical Cytology.

This scheme has been in operation in the county since September, 1965, and clinics are held in all the larger towns. These " Well Woman " clinics offer screening tests to exclude precancerous conditions of the cervix to all parous women mainly between 35–60 years who receive a pelvic examination and the taking of a cervical smear. The women doctors in charge of the clinics also carry out a breast examination and arrange for the urine to be tested for any abnormal constituents. Not infrequently gynaecological abnormalities are discovered on examination and in these circumstances the clinic doctors refer the patient to the family doctor for treatment. Women attend either by directly seeking an appointment or are referred by the family doctors.

Although the majority of the clinics are held during the day, some are evening clinics, and in addition teams visit some of the larger factories or industrial concerns employing women workers. A domiciliary service is provided where the situation demands it, i.e. if women are unable to attend a local clinic either for domestic or other reasons specially trained midwives visit the home and carry out the test.

The table shows the details of the work done during 1970.

Well Woman Clinics.

Table 6.—Number of Women Attenders and Results.

Division	(1) Number of women first attendances	Results of tests			(2) Subsequent attendances	Results of tests			(3) Re-test 3 years	Results of tests		
		Negative	For re-test	Further investigation recommended		Negative	For re-test	Further investigation recommended		Negative	For re-test	Further investigation recommended
South-West	502	502	—	—	112	109	2	1	50	50	—	—
East	949	921	25	3	75	75	—	—	280	263	17	—
St. Albans	1,263	1,105	154	4	149	117	32	—	341	272	68	1
Dacorum	894	612	276	6	276	261	14	1	—	No 3-year re-test. 5-year test starting 1971		
North	945	861	82	2	116	80	33	3	252	220	17	15
Mid	1,419	1,380	25	14	168	159	2	7	170	161	2	7
Total	5,972	5,381	562	29	896	801	83	12	1,093	966	104	23

CARE OF MOTHERS AND YOUNG CHILDREN.

BIRTH AND INFANT MORTALITY STATISTICS, 1961–70.

——— Hertfordshire – – – – – – England and Wales.

Live birth rate per 1,000 population.

Stillbirth rate per 1,000 births.

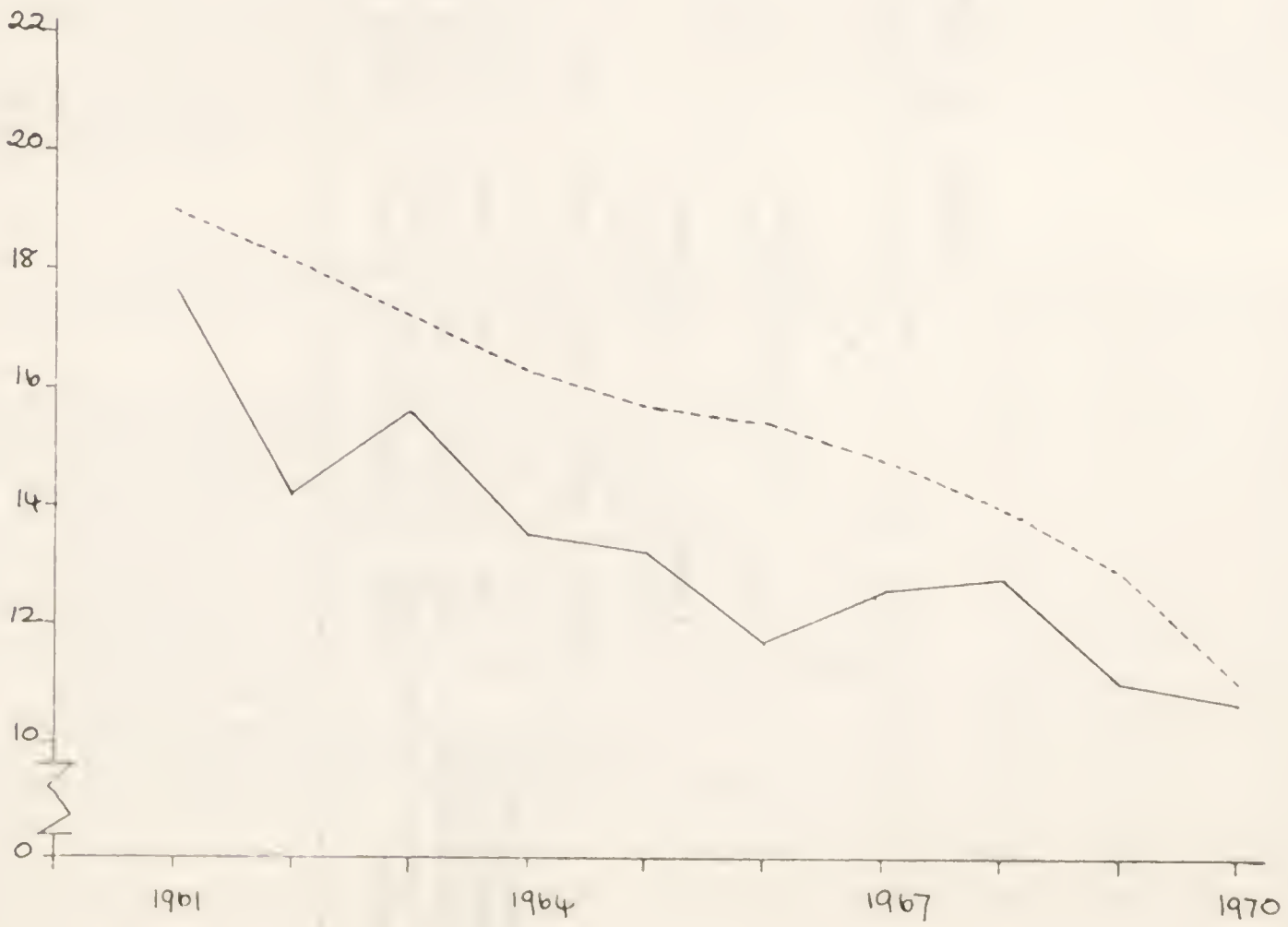
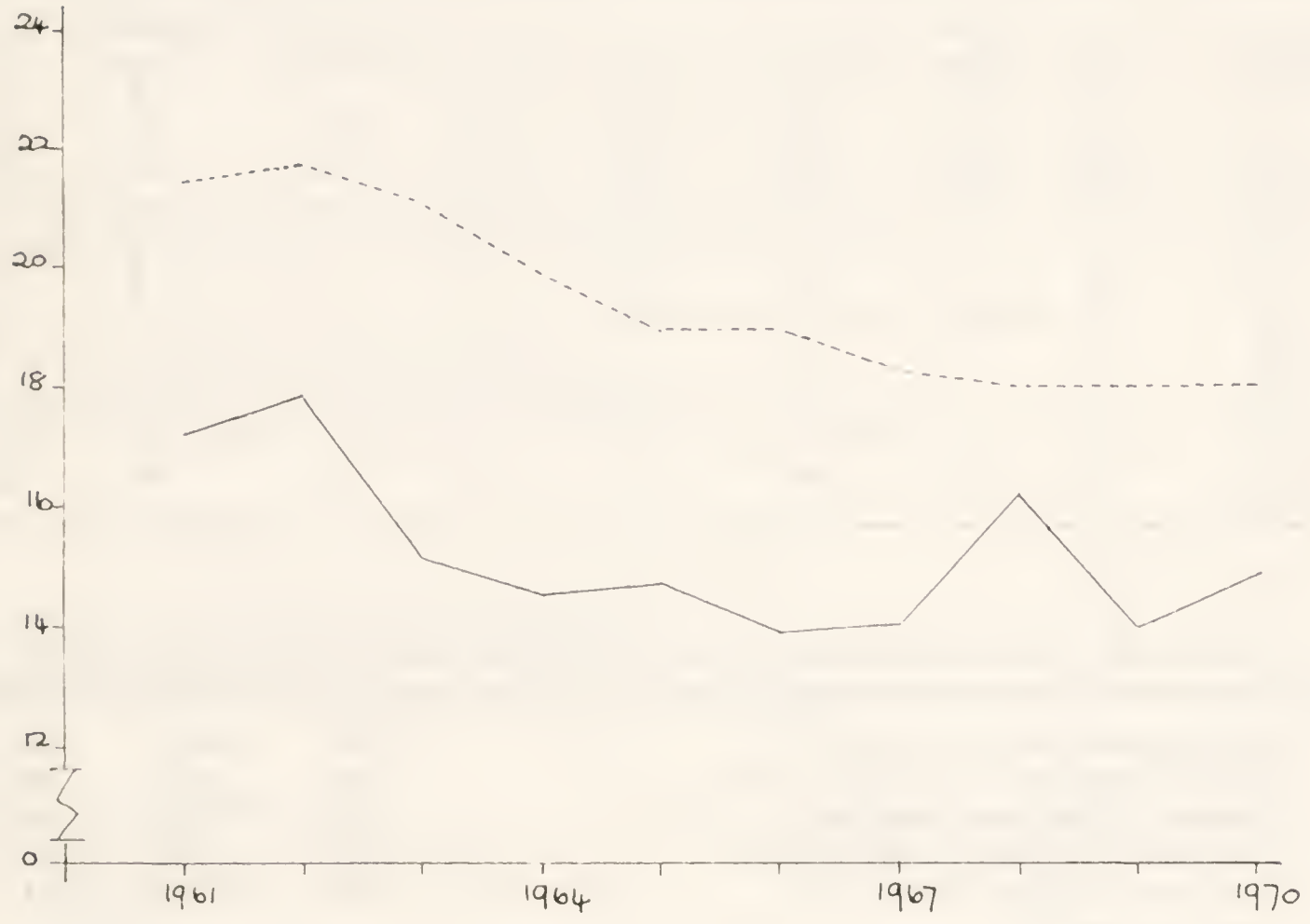


TABLE 7.—LIVE BIRTHS AND INFANT DEATHS, 1970.

	A. No. of Live Births					B. No. of Infant Deaths (under one year)						C. No. of Infants who died under four weeks					
	Legitimate		Illegitimate			Legitimate		Illegitimate				Legitimate		Illegitimate			
	Males	Females	Males	Females	Total	Males	Females	Males	Females	Total	Rate per 1,000 live births	Males	Females	Males	Females	Total	Rate per 1,000 live births
Borough and Urban districts	5,045	4,915	306	288	10,554	80	63	8	8	159	15·1	51	47	6	6	110	10·4
Rural districts	1,831	1,675	106	103	3,715	27	20	3	3	53	14·3	22	16	2	3	43	11·6
County	6,876	6,590	412	391	14,269	107	83	11	11	212	14·9	73	63	8	9	153	10·7

Infant mortality rate per 1,000 live births.



Day Nurseries.

The total number of children on the county council day nurseries registers was 386. Of this number 41·7 per cent of those admitted were children of deserted wives or husbands, and 30·3 per cent were children of unmarried mothers.

There were 70 nursery nurses, state registered nurses, and nursery assistants employed ; and the staff were engaged in assisting in the practical training of nursery nurses whose training is organized by the Education Department.

During the year the Bushey Day Nursery premises were relinquished and the children and staff transferred to new purpose built premises at Otley Way, Oxhey. Additionally, the Beechwood Day Nursery was able to increase its number of children and staff as an extension had been built to accommodate a further 20 children.

Table 8.—Categories of Children in Day Nurseries.

	1970.	*1969.*	*1968.*
(1) Children of widow or widowers	16	13	12
(2) Children of unmarried mothers	117	119	113
(3) Children of deserted wives or husbands	161	153	138
(4) Children of parents in prison	—	—	—
(5) Children of parents suffering from chronic illness or disablement	7	13	3
(6) Children of parents suffering from temporary illness, confinement, etc.	19	23	28
(7) Children recommended by doctor or health visitor for temporary help	53	42	61
(8) Children of essential workers in social services	2	2	3
(9) Children living in bad housing conditions	7	9	6
(10) Children where there is risk of break-up in family	4	1	3
	386	375	367

TABLE 9.—INDIVIDUAL NURSERIES—CHILDREN IN CATEGORIES.

Category.	*Noel.*	*Cole Green.*	*Chestnuts.*	*Fleetville.*	*Otley.*	*Beechwood.*	*Boreham Wood.*	*Total.*
1	2	3	3	2	—	1	5	16
2	12	12	15	30	17	16	15	117
3	22	15	16	22	22	44	20	161
4	—	—	—	—	—	—	—	—
5	—	—	—	6	1	—	—	7
6	3	—	—	5	5	1	5	19
7	2	6	14	12	5	9	5	53
8	1	—	1	—	—	—	—	2
9	—	2	4	1	—	—	—	7
10	3	—	1	—	—	—	—	4
Total	45	38	54	78	50	71	50	386

TABLE 10.—NURSERIES AND CHILD MINDERS REGULATION ACT, 1948.

Registrations and Inspections.	*1970.*	*1969.*	*1968.*
Persons registered at the end of the year	769	535	287
Number of children permitted	2,708	2,157	2,146
Premises registered at end of year	273	225	203
Number of children permitted	7,238	6,022	5,411
New registrations :			
Persons	336	384	76
Premises	101	50	56
Visits by nursing officers (effective)	546	1,063	555
Visits by health visitors (effective)	3,934	3,135	2,471

TABLE 11.—PERSONS AND PREMISES IN DIVISIONS.

	Persons.	*Premises.*	*Total persons and premises.*	*Number of children permitted for persons and premises.*
East	158	54	212	1,826
Hemel	82	41	123	1,357
North	201	41	242	1,645
South West	152	56	208	2,081
Mid-Herts	76	43	119	1,404
St. Albans	100	38	138	1,633
	769	273	1,042	9,946

Table 10 shows the registration and inspection of persons and premises under the Nurseries and Child Minders Regulation Act, 1948. In 1968, amendments to the Act were made, one being that all persons who mind 1 child for 2 hours or more during the day are required to register with the local authority. The effect of this amendment became apparent immediately and the number of persons registered at the end of 1970 had risen by 63 per cent in the 2 years. At the same time there was a rise of 20 per cent in the total number of children permitted for day care in the county.

During 1970 there was a slowing down in the new registrations (an increase of 0·7 per cent) though the total increase since the new regulations amounted to 69 per cent and it might appear that the figure had now reached its optimum.

The initial visits to all applicants are made by the divisional nursing officers but whereas in the past they continued to pay a further 2 supervisory

visits each year, this year this has proved impossible owing to the overall increase of work, but the supervision has been maintained by the health visitors whose visits have risen by 21 per cent.

Unmarried Mothers.

The Senior Social Worker (Miss Marjorie Lawrence) of the St. Albans Diocesan Council for Social Work reports as follows :—

Illegitimacy cases referred to Herts Social Workers in 1970.

Illegitimate maternity—new pregnancies	346
Miscellaneous cases which related to illegitimacy	66
Number of cases where work is continuing from previous years	250
Total	662

Total number of babies born in 1970.	*1970.*	*1969.*
Mother delivered in own home, ambulance, etc.	3	5
Mother delivered in hospital	255	251
Mother delivered in hospital from Mother and Baby Home	47	66
Child—Kept by mother	189	187
Adopted	83	105
In local authority of voluntary care	5	6
Stillborn	2	3
Died within 14 days	6	3
Died after 14 days	1	—
Decision pending	19	18
	305	322

Two of the most obvious facts to emerge from the 1970 statistics are :—

(i) the increased percentage of mothers who have kept their babies ; and

(ii) that more clients have come from the 16–18 age group.

346 mothers-to-be were referred in 1970 compared with 410 in 1969 ; this significant drop has come mainly from our North East Herts area where there has been an almost 25 per cent reduction in referrals.

One of the most often repeated cries for help that has come from the social workers has been for accommodation—for ante-natal patients and for those who have kept their babies. The Diocesan Mother and Baby Home maintains a steady flow of residents and is well booked up into the future ; however, not all mothers-to-be are able to benefit from this kind of care and some need a more distinctly individual approach—especially if they have already spent a large slice of their lives in institutions of various kinds. This is where we call upon the community to help us and we have in fact got a small number of families who will take an expectant mother into their homes. It is even more difficult to find accommodation for a mother who is pregnant and who already has one or more children. She may be unmarried, divorced, or separated from her husband. Separation is very hard for both mother and child particularly at this time and where possible we try to ensure that they stay together. The post natal patients are more difficult to house—especially if they have more than one child. It has already been stated that more mothers choose to keep their babies and while this is to be applauded it does bring with it some very difficult problems. Some families are able to absorb an illegitimate child without too much upheaval, but many cannot do this ; even with skilled help they are often unable to cope with the new emotional pressures and material demands that are put upon them and the mother makes her decision to leave the family

home with her child. Some of these girls are very young ; some not very bright. It is possible to help an older more mature girl by offering her a residential job where she can have her child with her—but only a few can cope with this kind of life. The others have to be housed and supported somehow.

On the question of accommodation it is probably true to say that our prime concern is for the illegitimate child and its well-being. Many have to bear the brunt of the mother's tension and frustration and unless she is given adequate help and support the illegitimate child will always be " at risk ".

TABLE 12.—WELFARE FOODS.

Commodity	Issues				
	At full price	At reduced price against coupons	Free against coupons	To day nurseries and hospitals	Totals
National dried milk . .	11,681	7,286	1,007	91	20,065
Cod liver oil . . .	8,327	—	1,125	42	9,494
Vitamins A and D tablets .	13,606	—	101	—	13,707
Orange juice . . .	364,006	—	5,854	2,539	372,399

Number of Distribution Centres 138.

My gratitude is once more extended to those people who continue to sell National Welfare Foods. This work is done voluntarily.

The trend of past years is continuing and there is a marked reduction in the issues of National Dried Milk and vitamins A and D tablets, and a rise in the number of bottles of orange juice distributed.

HEALTH VISITING.

At the end of the year there were 170 health visitors employed representing the equivalent of 147 full-time workers. In addition there were 5 specialized full-time visitors working with persons suffering from tuberculosis and other chest diseases.

Health visitors have part-time nurses (state registered and enrolled nurses) to assist them with non health visiting duties in clinics and schools. The number in employment was 73, making a full-time equivalent of 34·43.

21 nurses were sponsored by the authority for one year's Health Visitors' Training Course and completed the course during the year. A further 18 commenced the course in September, 1970.

14 field work instructors (health visitors) assisted with the students' practical training.

Refresher Courses and In-service Training.

17 health visitors attend courses outside the County and the majority of the health visiting staff participated in the series of study afternoons, which are held annually during the autumn.

In addition to this 23 health visitors attended 20 sessions on mental health at Napsbury Hospital, which were conducted by the consultant psychiatrist, and a 2-day course in the testing of infants' hearing was arranged for 19 health visitors, most of them new to the County, who had had no previous training in this diagnostic procedure.

TABLE 13.—CLINIC SESSIONS ATTENDED BY HEALTH VISITORS.

Type of session	Local authority	G.P. Surgery	Hospital	Total
Child health	11,857	1,005	—	12,862
Vaccination and immunization	2,286	811	—	3,097
Geriatric	—	74	37	111
Paediatric	—	—	303	303
Tuberculosis	—	—	823	823
Venereal disease	—	—	301	301

TABLE 14.—HOME VISITS PAID BY HEALTH VISITORS.

Type of visit	Number of 1st visits	Number of re-visits	Total no.	Percentage of total visits
Children under 5 years	72,567	114,703	187,270	78·5
Aged over 65 years	6,559	14,648	21,207	8·9
Mentally ill	733	2,911	3,644	1·5
Physically disabled	693	1,884	2,577	1·1
Social problems	2,659	7,213	9,872	4·1
Nurseries and child minders	976	2,958	3,934	1.6
Pre-adoption	328	644	972	0·4
Infectious disease	68	193	261	0·1
School nursing	—	5,375	5,375	2·0
Tuberculosis	847	3,556	4,403	1·8
Tuberculosis contacts	894	—	894	1·3
Tuberculosis B.C.G.	2,359	—	2,359	
Others	1,873	2,051	3,924	1·6
	90,556	156,136	246,692	100

Children under the age of 5 years.

As was shown in the survey carried out in 1969 on The Domiciliary Nursing Services in Hertfordshire (Published in the Medical Officer—23rd and 30th October, 1970) the main part of health visitors work is with children under the age of five years. 78·5 per cent of the total number of home visits were paid to this age group during 1970 and 12,862 child health clinic sessions were attended—of these 1,005 were held in general practitioners' surgeries.

There were also 3,097 sessions attended for vaccination and immunisation of which 811 were held in the surgeries.

For many years health visitors have had a close association with the paediatricians and attend hospital outpatient sessions on a rota system. 303 sessions were attended during the year.

Child Assessment Clinics have been established in three divisions and health visitors carry out initial screening tests on the babies (with subsequent referral to the medical officer where necessary) and close liaison with the paediatrician is maintained. Health visitors continue to visit adoptive parents and children placed for adoption, and reports on 328 children were forwarded to the Children's Officer in this respect.

The Elderly.

8·9 per cent of the total number of home visits were paid to the elderly. They may have been selected by the health visitor or referred by the general practitioner, a neighbour, a voluntary organization, or a district nurse. Visits usually involve general discussion and advice on health matters. As many of the elderly live alone this tends to be time consuming.

Some health visitors also attend hospital sessions with the geriatrician and

such liaison meetings concerning patients for discharge form an important link between the hospital and domiciliary services. In addition, some general practitioners have organized special advisory/screening sessions for the elderly which are attended by the health visitors and district nurses, where much useful health education can be carried out.

Tuberculosis and other Chest Diseases.

The tracing and testing of contacts of persons with tuberculosis is an important part of the work of the visitor. In this respect 2,359 home visits were made and a further 894 in connection with B.C.G. vaccinations.

Visits, for advisory purposes only, to persons with non-tubercular chest diseases, amounted to 514 (0·2 per cent of the total visits).

Venereal Disease.

Selected health visitors attend hospital outpatient clinics in each division—to give social advice to the patients—and, in consultation with the consultant venerealogists, contacts are traced and followed up. 301 sessions were attended.

Social Problems.

A total of 9,872 (4·1 per cent) home visits were paid to families who had some type of social problem. Many of these were to broken homes or where there were financial difficulties. Many problems such as these are referred to social workers for subsequent follow-up and it depends on the circumstances whether the health visitor or the social worker continues the supporting visits.

Physically Disabled Persons.

693 persons were visited periodically during the year. Many of these require some structural alteration to their houses to assist in the day-to-day living. Others require medical or nursing aids to increase their mobility.

The Mentally Ill.

Again, health visitors and social workers co-operated in this sphere. 733 patients were seen by health visitors and 2,911 visits were paid.

The *Health Education* aspect of the work of the health visitors has shown that 921 teaching sessions were conducted in addition to 593 in the schools. Group discussions taking place in the general medical practitioners surgeries were gradually becoming more common.

With the development of the social services there has been some concern, as to whether the work of the health visitor will materially change. Table 14 shows that only 6·7 per cent of home visiting dealt with social problems, mentally ill, and handicapped persons. This confirms that it is essential that good communications and co-operation with social workers are fostered and reciprocated as the health visitors' work with children takes on a more scientific approach, e.g. with the routine ascertainment of hearing ; child development testing and the continued surveillance of infants at risk.

HOME NURSING.

There was a total of 256 state registered nurses working on home nursing duties, of which 57 were engaged whole-time (including 6 male) and 178 part-

TABLE 15.—TYPES OF CASES AND VISITS PAID.

	1970			1969			1968		
	Cases	No.	%	Cases	No.	%	Cases	No.	%
Medical . .	11,606	295,525	78·6	10,221	268,013	78·3	10,126	270,356	82·1
Surgical . .	3,488	73,730	19·6	2,717	71,098	20·7	2,259	56,071	17·0
Infectious diseases .	97	179	0·04	26	87	0·02	34	58	0·02
Tuberculosis .	26	656	0·07	36	885	0·26	52	1,111	0·3
Cytology . .	72	138	0·03	18	—	—	—	—	—
Others . .	1,188	5,723	1·5	542	3,407	0·9	578	1,671	0·5
Total: .	16,477	375,951	100	13,542	344,390	100	13,049	329,267	100

time. The latter also carried out midwifery and a small number had health visiting duties. 21 state enrolled nurses were also employed of which 5 were part-time only. The whole represent a full-time equivalent of 141 full-time staff.

The nurses attended 16,477 patients, and paid a total of 375,951 visits to them, an increase of 27,510 visits over the previous year. In the Table, 72 patients and 138 visits (to take cervical smears) are shown under Cytology ; this work was done in the East Division where the domiciliary service was started in late 1969. Nurses also attended 219 cytology sessions in general practitioners' surgeries and 689 in local health authority clinics.

The over 65 age group accounted for 67·1 per cent of all nursing visits, and 50·8 per cent of all patients were in this age group.

The work being done by nurses in general medical practitioners' surgeries continued to increase and 29,544 patients received treatment from the nurses and 477 were seen during screening procedures.

Night Nursing.

This service carried out by the State Enrolled nurses has remained almost static. 48 patients received care for a total of 128 nights.

Nursing Homes.

There were 8 registered nursing homes which received medical, surgical, and chronic sick patients. The total number of beds available was 161. Each nursing home was inspected by a local authority nursing officer.

Auxiliary Helpers.

The survey of work for all grades of nursing staff undertaken in 1969 revealed that trained nurses were carrying out some duties which could be done by auxiliary helpers. In the autumn of 1970 it was agreed that initially 2 full-time helpers could be employed in each division, as an interim arrangement, and that this number would increase in the following year. Their work was mainly concerned with the frail elderly and handicapped people and included assistance with personal toilet, dressing and undressing. A high proportion of elderly people live alone, and have no relatives to give this kind of assistance.

Training Courses.

Training courses in the technique and practice of district nursing were extended during 1970, to include state enrolled nurses, as well as state registered nurses, and more specialized courses were arranged for practical work instructors and auxiliary helpers.

In all, a total of 28 state registered nurses and 12 state enrolled nurses took the National District Nurses' Examination which is set by the panel of assessors of the Department of Health and Social Security. 26 state registered nurses passed at the first attempt and two at the second. All the state enrolled nurses were successful at their first attempt. Arrangements continue with the County Borough of Luton and Bedfordshire County Council for the theoretical training of four of their nurses in each course. Their practical work is assessed in the main by their own practical work instructors.

The course for practical work instructors was arranged to prepare the more experienced district nurses to teach practical skills to new staff and student nurses from hospitals within the County. In accordance with the General Nursing Council 1969 syllabus, student nurses are required to undertake one option during their training which may be in either psychiatry, geriatric nursing, obstetrics, or community care. During the year, preliminary visits were made to the teaching departments of some of the hospitals to discuss the community care nursing project which will probably start in 1972.

The 1-week auxiliary helpers course was planned as a method of induction to new members of the staff. Arrangements were also made for 6 nurses to attend courses arranged by other bodies.

This year has also seen the start of an integrated state enrolled nurse/district nursing course at Abbots Langley Hospital. The earlier planning of this course was made in conjunction with the Queens' Institute of District Nursing, who pioneered the state enrolled nurse/district nurses' training but the final arrangements were approved by the panel of assessors of the Department of Health and Social Security. Following an introductory talk early in their training, each pupil spent 2 days accompanying a district nursing sister on her visits and 3 pupils who showed interest in the type of work were accepted for this course. After 1 year's hospital training they had a further 2 weeks domiciliary experience and the course will be completed during 1971 when they will join one of the state enrolled nurse/district nurse training courses for 1 week of study and a further 5 weeks practical experience before taking their National Examinations.

The extension of courses has considerably increased the work in this section and it was found necessary to increase the tutorial staff by seconding a group adviser to assist in the general organization of these training courses.

VACCINATION AND IMMUNIZATION.

The number of immunizations and vaccinations given to Hertfordshire children during 1970 is shown in Table 17. The change of schedule in 1968 makes comparison with earlier results difficult, but the previous three years' figures have been included for interest. Nearly all the reinforcing doses given in 1970 were pre-school boosters.

A considerable amount of work was involved in attaining the current high protection rates, but it can be justified by the low incidence of the relevant diseases. (See Table 16.) Since measles vaccination began in 1968, the biennial epidemic pattern of the disease appears to have been modified, as can be seen from the graph on page 28.

In Hertfordshire it has been found that approximately a quarter of the child population change addresses each year. Each week, too, about 70 children move into Hertfordshire from other Counties. It is very desirable that courses of immunization should continue smoothly for these children. The greater and speedier interchange of information now possible by computer application of immunization records, together with a more universally applied immunization schedule, helps to ensure that this is done.

TABLE 16.—NOTIFICATIONS OF INFECTIOUS DISEASES, 1970.

The mortality figures resulting from the infectious diseases will be found in Table 2.

District	Scarlet Fever	Whooping Cough	Acute Poliomyelitis: Paralytic	Acute Poliomyelitis: Non Paralytic	Measles	Diphtheria	Acute Pneumonia	Dysentery	Smallpox	Acute Encephalitis: Infective	Acute Encephalitis: Post-Infective	Enteric or Typhoid	Paratyphoid	Erysipelas	Meningococcal Infection	Food Poisoning	Puerperal Pyrexia	Ophthalmia Neonatorum	Chicken Pox	Malaria	Undulant Fever	Infective Jaundice	Leprospirosis	Tuberculosis: Pulmonary	Tuberculosis: Non-Pulmonary	Scabies	Totals for Districts
BOROUGHS—																											
1 Hemel Hempstead	4	2	—	—	124	—	—	4	—	—	—	—	—	—	3	53	—	—	—	1	—	10	—	8	2	—	211
2 Hertford . .	5	—	—	—	7	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	4	—	—	17
3 St. Albans . .	9	1	—	—	68	—	—	8	—	—	—	—	—	—	1	3	—	—	—	—	—	5	—	17	7	—	114
4 Watford . .	5	6	—	—	79	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	1	23	—	—	124
Totals Boroughs .	23	9	—	—	278	—	—	13	—	—	—	—	—	—	4	56	—	—	—	1	—	18	1	52	11	—	466
URBANS—																											
1 Baldock . .	1	—	—	—	10	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	10	—	1	2	—	12
2 Berkhamsted .	—	—	—	—	26	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	9	—	—	—	—	36
3 Bishop's Stortford	1	—	—	—	12	—	—	1	—	—	—	—	—	—	—	1	—	—	—	—	—	11	—	1	1	—	28
4 Bushey . .	1	6	—	—	52	—	—	2	—	—	—	—	—	—	—	11	—	—	—	—	—	3	—	2	1	—	78
5 Cheshunt . .	17	8	—	—	279	—	—	—	—	—	—	—	—	—	1	3	—	—	—	—	—	5	—	3	—	—	310
6 Chorleywood .	—	—	—	—	4	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—	14
7 Harpenden . .	—	—	—	—	23	—	—	—	—	—	—	1	—	—	—	3	—	—	—	—	—	2	—	2	1	—	32
8 Hitchin . .	4	—	—	—	97	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	8	1	—	111
9 Hoddesdon . .	—	3	—	—	68	—	—	1	—	—	—	—	—	—	—	5	—	—	—	—	—	—	—	3	3	—	83
10 Letchworth . .	—	1	—	—	63	—	—	—	—	—	—	1	—	—	—	—	—	1	—	—	—	—	—	3	—	—	69
11 Potters Bar . .	12	12	—	—	215	—	—	1	—	—	—	—	—	—	—	2	—	—	—	—	—	—	—	1	1	—	244
12 Rickmansworth .	2	3	—	—	60	—	—	55	—	—	—	—	1	—	—	4	—	—	—	—	—	1	—	3	—	—	129
13 Royston . .	1	—	—	—	49	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—	52
14 Sawbridgeworth .	1	—	—	—	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3
15 Stevenage . .	34	18	—	—	522	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	11	—	6	—	—	592
16 Tring . . .	—	1	—	—	97	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	99
17 Ware . . .	1	1	—	—	5	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	1	—	1	1	—	11
18 Welwyn Garden City	7	3	—	—	228	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	240
Totals Urbans .	82	58	—	—	1,812	—	—	61	—	1	—	4	1	—	1	31	—	1	—	—	—	55	—	37	11	—	2,143
RURALS—																											
1 Berkhamsted .	—	2	—	—	13	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	1	—	19
2 Braughing . .	2	1	—	—	10	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	14
3 Elstree . .	29	8	—	—	132	—	—	—	—	—	—	—	—	—	—	6	—	—	—	1	—	12	—	9	1	—	198
4 Hatfield . .	15	2	—	—	414	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	7	—	3	1	—	443
5 Hemel Hempstead .	2	—	—	—	16	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	3	—	—	22
6 Hertford . .	3	—	—	—	11	—	—	34	—	—	—	—	—	—	—	2	—	—	—	—	—	—	—	2	1	—	53
7 Hitchin . .	8	1	—	—	50	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	—	62
8 St. Albans .	5	6	—	—	120	—	—	5	—	—	—	—	—	—	—	4	—	2	—	—	—	8	—	10	2	—	162
9 Ware . .	1	5	—	—	23	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	17	—	2	—	—	49
10 Watford . .	5	18	—	—	230	—	—	24	—	1	1	—	—	—	—	17	—	—	—	—	—	9	—	6	—	—	311
11 Welwyn . .	2	—	—	—	9	—	—	5	—	—	—	—	—	—	—	5	—	—	—	—	—	—	—	—	—	—	21
Totals Rurals .	72	43	—	—	1,028	—	—	70	—	1	1	—	—	—	—	35	—	2	—	1	—	56	—	39	6	—	1,354
Totals County .	177	110	—	—	3,118	—	—	144	—	2	1	4	1	—	5	122	—	3	—	2	—	119	1	128	26	—	3,963

TABLE 17.—IMMUNIZATIONS AND VACCINATIONS.

Immunizations	1970	1969	1968	1967
SMALLPOX.				
Primary	10,501	11,083	11,267	10,811
Re-vaccination	998	1,171	1,019	768
Totals	11,499	12,254	12,286	11,579
DIPHTHERIA.				
Primary doses	11,763	6,886	15,665	14,122
Reinforcing doses	14,148	21,771	20,786	20,894
Totals	25,911	28,657	36,451	35,016
WHOOPING COUGH.				
Primary doses	11,275	6,446	14,121	13,494
Reinforcing doses	3,188	12,515	11,622	11,820
Totals	14,463	18,961	25,743	25,314
TETANUS.				
Primary doses	12,082	7,339	15,118	14,533
Reinforcing doses	15,230	22,645	22,061	21,702
Totals	27,312	29,984	37,179	36,235
POLIOMYELITIS.				
Primary doses	12,019	7,620	16,188	15,597
Reinforcing doses	15,483	21,959	19,840	16,898
Totals	27,502	29,579	36,028	32,495
MEASLES	18,108	10,430	12,981	—
GERMAN MEASLES	2,581	—	—	—

Measles notifications (vaccination began in 1968).

CARE AND AFTER-CARE.

Tuberculosis.

The fall in the number of notifications of new cases of tuberculosis continued in 1970 (Table 18), although as will be seen from the extracts from the reports from the chest physicians which follow, there were still some persons quite severely affected.

The part that smoking plays as a causal agent in chest conditions is emphasized by more than one physician, and the health education staff of the authority are fully conscious of the importance of " putting over " to as many groups as possible in schools, colleges and elsewhere, the dangers of indulgence in this particular habit.

Dr. Hounslow of Barnet in his report refers to the B.C.G. scheme for children and others. Table 19 shows the details of what has been done in this connection in the County as a whole. The local authority scheme offers vaccination to entrants into secondary schools and also to other childre in these schools who have not been previously tested who are found on testing to be susceptible to tuberculosis. Children who show a marked reaction to the tuberculin test are referred to the chest physicians for any further investigations thought suitable.

Table 18.—Notifications of Pulmonary and Non-pulmonary Tuberculosis.

	1970				1969				1968			
	No. of cases notified			Attack rate per 1,000 pop.	No. of cases notified			Attack rate per 1,000 pop.	No. of cases notified			Attack rate per 1,000 pop.
	M	F	Total		M	F	Total		M	F	Total	
Pulmonary.												
Urban . .	55	34	89	0·14	65	36	101	0·16	80	43	123	0·19
Rural . .	26	14	40	0·15	23	15	38	0·13	43	19	62	0·23
County . .	81	48	129	0·14	88	51	139	0·15	123	62	185	0·21
Non-Pulmonary.												
Urban . .	12	8	20	0·03	8	12	20	0·03	11	18	29	0·04
Rural . .	3	3	6	0·02	1	5	6	0·02	2	6	8	0·03
County . .	15	11	26	0·03	9	17	26	0·03	13	24	37	0·04
Pulmonary and Non-Pulmonary												
Urban . .	67	42	109	0·17	73	48	121	0·19	91	61	152	0·24
Rural . .	29	17	46	0·17	24	20	44	0·16	45	25	70	0·26
County .	96	59	155	0·17	97	68	165	0·18	136	86	222	0·25

Table 19.—B.C.G. Vaccination.

	Schoolchildren approximately 12 years of age.
1. Skin tested	12,154
2. Positive reactions :	
(*a*) In children who had already received B.C.G. vaccination but more than five years previously	543
(*b*) In children who had not previously been vaccinated	205
3. Negative reactions	10,766
4. Vaccinated	10,695

Report of Dr. P. W. Roe and Dr. J. H. Angel, South-West Division :—

In 1970, new notifications of tuberculosis fell to a new low level of 47 new cases, 8 less than the previous lowest in 1965. There were 15 immigrants among the new cases as compared with 7 in 1965. Thus the proportion of immigrants among new cases has risen from 13 per cent in 1965 to 32 per cent in 1970.

The number of persons under regular supervision for tuberculosis has fallen from 2,765 in 1965 to 2,024 in 1970. The work load on the tuberculosis health visitors remains at a high level owing to the difficulties arising from immigrant families who speak little English, and also because of the fact that a much higher proportion of patients are treated entirely at home and have to be carefully supervised. The introduction of new anti-tuberculosis drugs for drug-resistant cases, Capreomycin, Ethambutol, and Rifampicin, and the B.T.T.A. Trials on the effectiveness of these drugs on patients living at home, has necessitated daily visits by the health visitors to ensure the correct administration of the treatment for those patients in the trials.

One of us (Dr. J. H. Angel) is the Secretary of the Clinical Trials Committee of the British Thoracic and Tuberculosis Association and the Department has been significantly involved in the research work of this organization.

The treatment of long standing positive sputum cases at home still remains a time consuming process for all clinical members of the staff, but this work is vitally necessary if the disease is to be brought under control. In 1965, the number of cases known to have been infectious during the year was 31 and this rose subsequently, but in 1970 it has fallen to a new low level of 27 cases only. This progress is a tribute to the work of the department as a whole but more especially, to the careful supervision of cases on treatment at home, without which many more patients would fail to co-operate, and relapses would occur with further spread of infection.

Report of Dr. N. MacDonald, North Herts Division :—

New notifications in 1970 totalled 21 as compared with 22 in 1969. Only 6 were sputum positive. 7 were immigrants, none of whom were sputum positive. Bronchial carcinomas totalled 56 compared with 52 in 1969. In all, 904 new patients were seen as compared with 886 in 1969. Total attendances were 6,291 (1969—6,222). The returns for the two years are therefore remarkably similar with tuberculosis remaining at its previous low level. The major part of the Clinic's work has been concerned with patients suffering from asthma, chronic bronchitis and emphysema and bronchial carcinoma.

The role of cigarette smoking in chronic bronchitis, as well as in bronchial carcinoma, has become increasingly recognized and patients suffering from this and other chest conditions are routinely advised to stop. Obtaining a record of the patient's smoking habits is now an accepted part of the investigation for chest disease and advice on stopping smoking is regarded as valuable preventive medicine. The publication of the second report of the Royal College of Physicians on smoking has made people not only more aware of the danger but more ready to accept advice from doctors. Some indeed come expecting to be advised to stop and should not be disappointed in this respect. The real problem for the future, however, is how to deal with the cohort of children who are approaching the age at which they will be tempted to smoke. Some will be hooked from the time they smoke their first cigarette and will pay daily toll financially for the rest of their lives as well as in terms of damage to health in later years. Parents and teachers, as well as the mass media and the medical profession have a part to play in combating this continuing menace to life and health.

Report of Dr. Rhys Jones (Cheshunt Clinic) :—

Honey Lane Hospital.

The work in the clinic continued to be concerned mostly with bronchial disease. The first task of the chest physician in cases of bronchitis is to persuade

his patient to give up smoking. This year's report of the Royal College of Physicians has certainly helped, in that compared with a few years ago one rarely finds a patient prepared to indulge in polemics regarding smoking. We are only one step further on, however, for there is still considerable difficulty in persuading him to give up smoking, even when he recognizes cause and effect. " Persuasion " is the operative word for the physician has very little else.

In an ideal world a " rational approach " would suffice ; when people learnt the facts of the case they would take the necessary action, but unfortunately it is rare for this to happen in regard to smoking.

The " psychological approach " has a great attraction to those who only wish to play a passive role in curing themselves of smoking. We have little knowledge of the psychology of habits like smoking, and there is only a limited place for psychological methods in treatment.

This leaves us finally with the use of " moral persuasion ". Here the persuader may expect obedience from the persuaded because a special relationship exists between the two. Many a parent hopes that he has such a relationship with his child and we doctors believe that we have it with our patients, but alas our hopes are often unfounded.

There is an area where influence is particularly strong, and where hope of success can be looked for, and that is within the social group. We all wish to conform to the customs and habits of our own community, whether this is our own age group, a profession or a social club. This leads to the " moral responsibility " of those working in the health services, particularly those working in the preventive service. The tradition that a doctor need not practice what he preaches has been broken. In regard to smoking it is well known that doctors are carrying out their own advice. It is disappointing to learn that the nursing profession for example, has not yet followed suit. When, on a recent television programme, a physiotherapist responsible for treating respiratory cripples at a London hospital confessed that she herself was unable to give up smoking, there was clearly a considerable weakening of the whole argument against smoking.

As a chest physician one feels entitled to ask all members of the preventive services, lay and professional, to consider their attitude towards this habit of smoking.

Report of Dr. T. A. Watkin Edwards, St. Albans, Mid-Herts areas :—

33 patients diagnosed as suffering from pulmonary tuberculosis in 1970. 7 of these were positive on direct examination of the sputum, 2 positive only on the culture. All the others were negative. No fewer than 11 of the cases were discovered as a result of contact examination, the source case being in each case positive on direct examination. This illustrates the value of extensive contact work. Although the majority of cases were relatively mild there were four really extensive cases with bilateral disease and cavitation. These are the people it is most important to find and to ensure that they receive adequate prolonged treatment as they are the main source of infection which results in the perpetuation of Tuberculosis in the community.

Over the last few years there has been considerable change in the character of the chest clinic work, more cases of lung cancer, chronic bronchitis and, in particular, asthma being seen each year. One has the impression that more severe cases of asthma are occurring ; certainly more are being referred to us. They constitute an interesting but difficult and time-consuming group of patients who make a considerable demand on the clinic facilities and quite often require urgent admission in status asthmaticus. Both the health visitor and the medical social worker are able to contribute to the welfare of these non-tuberculous patients in numerous ways.

Report of Dr. John C. Roberts, Dacorum Division :—

During the last year we have, according to the policy of the chest clinic.

continued to discharge patients whose tuberculous disease appears to have been healed.

The link up of the clinic with the health visitors has proved very satisfactory. The hospital medical social worker has been very helpful. Although this re-organization has meant a reduction in our staff it has not appeared to have impaired the efficiency of the service.

The number of new patients referred to the clinic has continued to rise The mass radiography service has proved of great benefit to the area, all abnormalities being referred to us. Our " X-ray Only " session at the hospital has, therefore, not been unduly overstrained. It would appear desirable in this region, in view of the scattered area and the pressure on the hospital X-ray department, that the mass radiography service should be continued.

Extract of report of Dr. A. G. Hounslow, Barnet area :—

B.C.G. in School Children.

In addition to 8 children who had missed the B.C.G. sessions at school, 191 children were referred by school medical officers because of a positive tuberculin test (all grades of Heaf reaction). All the tuberculin positive children were seen, in most cases with a parent, not only to elicit any history of contact or previous vaccination, but also in order to answer question and allay anxiety. In some cases it was possible to detect B.C.G. scars even where there was no clear recollection of vaccination. (Many of these children were immigrants, and it is worth noting that in some countries, e.g. Kenya, the vaccine is normally administered adjacent to the elbow.) Where there seemed to be an obvious explanation of the tuberculin sensitivity (previous B.C.G., calcified foci, history of old contact, etc.), one X-ray was deemed sufficient. Where no such explanation was forthcoming, the child was asked to return for a further film in 6 months' time.

The findings were as follows :—

History.		
Known contact, no B.C.G.	9	
Known contact, B.C.G.	5	
B.C.G. without known contact	22	
No known contact or B.C.G.	155	
	191	
X-rays.		
Normal	186	(132 repeat films, all normal
Calcified foci	2	
Possible hilar enlargement	1	
Active primary disease	2	
	191	

Both the children with calcified foci had had past tuberculosis contact but had not received B.C.G. The child (Indian) with possible hilar enlargement had no clinical evidence of disease. A repeat film in 3 months was less alarming and he then returned to India. The 2 English boys with active disease admitted to recent contact with a cousin in Devon with open tuberculosis. Both had well marked (grade 3) reactions.

Towards the end of the year it became apparent that larger numbers of children than usual were being referred, and in fact the numbers rose from 68 in 1968 to 131 in 1969, and 191 in 1970. The later referrals were, therefore, questioned carefully as to the type and size of reactions, (with the aid of diagrams and colour photographs), and the test site was carefully scrutinized. Of 42 children so questioned, a reaction of grade 1 or less was described by 24, and this was confirmed by the absence of any residual induration at the test site. 7 children described grade 2 reactions and 6 children grade 3. The child with

possible hilar gland enlargement described a grade 4 reaction. Where the higher grades of reaction were described it was not uncommon to find confirmatory evidence in the form of residual induration. In 4 cases where there seemed some doubt as to whether the reaction had been as much as grade 1, the test was repeated ; all were negative and the children received B.C.G.

This raises important issues. No child who is really tuberculin negative should be denied the benefit of vaccination and little harm would be done in most cases by vaccinating children who are in fact tuberculin positive although there might be a few large local reactions. The problem is not merely that of deciding the correct *grade* of reaction, but also the *significance* of the various grades, and there has been much discussion in recent years on this subject. As a recent article* points out, there is evidence to suggest that many if not most grade 1 reactions in young people in this country are due to sensitization to other sensitins than the mammalian tubercle bacillus. The significance of grade 2 reactions is less clear, but only a proportion of these may be attributable to true M. tuberculosis sensitization. For this reason many workers are now ignoring grade 1 reactions in their vaccination programmes, and some would even advocate ignoring grade 2 reactions. The whole problem clearly needs ventilation and some measure of agreement and uniformity reached.

Convalescence.

Family doctors and hospitals continue to refer patients for convalescence although the numbers referred dropped quite considerably from the previous year. Approximately half the number were accepted at the Hertfordshire Seaside Convalescent Home near Hastings and half to other Convalescent Homes along the East and South Coasts.

In addition to providing convalescence for patients who have suffered illness, injury or operation, it was also felt necessary to help families who needed a respite from the responsibility of caring for the chronically sick or disabled members, and some of these handicapped persons were also included in the scheme. There is a great shortage of beds for severely handicapped persons and reservations require to be made some time in advance.

The age and infirmity of so many of those who go forward for convalescence are such that the provision of special transport, either to the main line station in London or all the way to the Home, is becoming more and more necessary.

Medical Loan Scheme.

To support and maintain handicapped people within the community is an essential part of the work of the Health and Welfare Department. One aspect

Table 20.

	1970.		*1969.*	
Applications received from :—				
General practitioners	269		383	
Hospitals	9		32	
Social workers	2		10	
	—	280	—	425
Patients who were not acceptable for this scheme of the County Council	2		25	
Patients for whom no vacancy could be obtained owing to their condition	3		10	
Cancellations by applicants	60		105	
	—	65	—	140
Number sent to—The Hertfordshire Convalescent Home	106		153	
Other Homes	109		132	
	—	215	—	285

* The Heaf Test, Leading Article, " Tubercle " (Lond.) (1970), **51**, 207.

of this work is the supply of all forms of " aids " to enable these persons to be as independent as possible and to lessen the burdens on those looking after them in their homes. The assistance given by the council ranges from additions to and alterations within the homes, the supply of special beds, mattresses, hoists of many kinds, and different types of wheelchairs, down to small gadgets to increase mobility. The distribution of the large items of equipment is controlled from County Hall, but practically everything else is dealt with through the many loan depots throughout the county, and the council continue to be indebted to the members of the St. John's Ambulance Brigade and the British Red Cross Society for the voluntary work in manning these depots.

During the year 6 more houses required to be adapted for the installation of the special equipment to enable renal dialysis to be carried out there as an alternative to the patient's attendance at hospital 2 or 3 times a week.

AMBULANCE SERVICE.

There has been further progress in the development of the Ambulance Service during 1970.

1. *Ambulance Vehicles.*

The search for a more suitable type of chassis for ambulance work continues both locally and nationally but until a vehicle is developed specifically for ambulance purposes the county council have no alternative but to accept a standard mass-produced chassis with such modifications as are practicable. In these circumstances the Ford Transit Model 130 is considered to be the most suitable chassis at present available. A number of new Ford Transit Ambulances are fitted with automatic gear boxes and these are being evaluated both operationally and economically against those fitted with manually operated gear boxes.

All new ambulances now have a communicating door between the patient and driver compartment which not only acts as an emergency exit but allows ease of communication between attendant and driver and gives access to the attendant to operate the two-way radio whilst the driver is engaged on his duties.

Dual purpose ambulances of a larger passenger carrying capacity are being introduced to meet the increasing demand for the transport of hospital day patients.

2. *Ambulance Equipment.*

(*a*) *Entonox Analgesic Apparatus.*

Entonox, which is a mixture of 50 per cent nitrous oxide and 50 per cent oxygen contained in a single cylinder has for many years been safely self-administered during childbirth.

A medical team has carried ont a survey to test its suitability for ambulance work during which the equipment was used in ambulances by patients in pain. In all cases the pain was relieved and in none was the patients condition worsened.

In June, approval was given for 2 Entonox sets to be tried at St. Albans and Stevenage Ambulance Stations. The staff at these stations attended St. Albans City Hospital for lectures and practical instruction in the use of the equipment by the consultant anaesthetist. Comments from patients and staff on its use have been favourable. A number of Ambulance Authorities are using the equipment with equal success.

In view of the successful outcome of these trials it has been decided that all operational ambulances shall be provided with Entonox analgesic apparatus during the financial year 1971 72 and arrangements are being made for all ambulance crews to be trained in its use.

(*b*) *Portogen Oxygen Apparatus.*

The use of oxygen for relief of respiratory complaints is difficult using resuscitation apparatus which cannot be carried with the patient between bed and ambulance and distress is caused because of the inability to provide oxygen en route.

Successful trials have been carried out at selected ambulance stations during the year using the Portogen, a lightweight oxygen apparatus providing a flow of 4·5 litres of oxygen per minute for 20 minutes which is sufficient to give adequate relief to a patient being removed from bed to ambulance. The apparatus is supplied in a small canvas bag with a shoulder strap and can be carried by a crew member whilst lifting and carrying the patient.

Arrangements have been made for Portogen Oxygen apparatus to be carried on all operational ambulances after 1st April, 1971.

3. *Liaison with General Practitioners and Hospital Staffs.*

The ambulance service has endeavoured to foster greater coordination between hospital staffs and general practitioners by arranging visits to ambulance control centres and reciprocal visits to hospital departments by ambulance officers and control staff. This has proved valuable and gives a better understanding of the problems and difficulties of others.

Liaison is also maintained with Regional Hospital Board staffs and other interested parties when new hospital projects are planned for the county and this is continued at all stages of development. During the past year meetings have been held with representatives of the North West Metropolitan Regional Hospital Board, the Luton and Hitchin Group Hospital Management Committee, and County Medical Officer's staff in connection with the new Lister Hospital Project. These discussions proved advantageous to all concerned.

4. There has been a further increase in the demand on the ambulance service compared with last year. The increase in the number of patients carried was 3,365.

The graph on page 36 shows the demand on the service during the last 10 years compared with the growth of population.

During 1969, the number of patients carried by the directly provided service showed an increase of 0·51 per cent with a decrease in mileage of 0·40 per cent. In 1970, the number of patients carried shows an increase of 1·10 per cent with decrease in mileage of 0·62 per cent.

Table 21 shows the number of patients carried and the mileage involved in

TABLE 21.

	1969	1970	Increase or decrease	
Patients.				
Directly provided service . . .	335,123	338,826	Increase	3,703
Hospital car service	29,623	29,779	Increase	156
Isolation ambulance	61*	—		
Agency (Garston Manor Rehabilitation Centre vehicle)	5,405	4,972	Increase	433
Mileage.				
Directly provided service . . .	2,106,460	2,093,308	Decrease	13,152
Hospital car service	628,923	646,346	Increase	17,423
Isolation ambulance	390*	—		
Agency (Garston Manor Rehabilitation Centre vehicle)	10,745	11,062	Increase	317

* Ambulance withdrawn from Isolation Hospital in March, 1969, and put back into general service since when all infectious removals in Watford area have been dealt with by the directly provided service.

respect of the directly provided service, Hospital Car Service, and Agency Services for the years 1969 and 1970.

GROWTH IN AMBULANCE SERVICE FOR THE LAST TEN YEARS—COMPARED TO GROWTH IN POPULATION.

——— Ambulance cases conveyed (thousands)
– – – – – Population of County (thousands)

ENVIRONMENTAL HEALTH SECTION.

This report deals with the work of the County Health Inspector.

INTRODUCTION.

In writing an annual report, it is always difficult to be retrospective, especially when one is writing in a year notable for its pronouncements on the future pattern of local government and in which suggestions for far reaching environmental health administration changes have been made in a Government White Paper. However, there are many matters to be resolved in the current year and they will make a more fitting introduction to next year's annual report.

Under the aegis of the Council of Europe, 1970 was established as Conservation Year. Promotion of the conservation idea, covering many aspects of pollution, was outstandingly successful and there was a great increase in public awareness of the environmental problems which beset us today. Such awareness had existed previously but tended unfortunately to be limited to specialist groups dealing with specific problems. There is no doubt that the more widespread dissemination of knowledge has conditioned people to the restrictions which may have to be imposed in some sectors if pollution, in all its aspects, is to be kept within bounds.

The County Health Inspector presented a paper on the Assault on the Rural Environment which was read at a 1-day symposium organized by the Association of Public Health Inspectors in London at the beginning of the year. Reference was made to this paper at the Council of Europe's Conference in Strasbourg later in the year.

Milk and Dairies Administration.

(*a*) *Infection in Milk.*

Our farm sampling activities are confined to the detection of the organism brucella abortus. During the year a total of 968 samples were obtained and of these, 131 were " positive " by the ring test. More important, however, is the direct comparison between the number of farms which carry apparent infection and those which are negative : 34 farms had positive results during the year and 237 were negative.

As I have said in previous years, brucellosis control has left a great deal to be desired in this country. There is evidence to suggest that the voluntary eradication scheme in which infected animals could be culled from those farms seeking to join the voluntary " accredited " herds scheme run by the Ministry of Agriculture, Fisheries and Food, resulted in a spread of infection to otherwise clean farms. This was because there was no limitation on the sale of infected cattle unless sold through established brucella-free markets. A clause in the Agricultural Act, 1970, which made it an offence, punishable by a heavy fine, to sell cattle known to be reactors to brucella other than for slaughter, was particularly welcome. The farmer with reactors in his herd is faced with either selling them as beef animals, and thereby suffering a financial loss, or alternatively of keeping the infected animals with a possibility that infection might spread within his herd. This is rather like a game of musical chairs and, within the limits of legislative control, the music has now stopped. Undulant Fever, caused by drinking brucella infected milk, is a debilitating illness of sometimes long duration and one which is not always easy to diagnose. It is to be regretted that the legal control provided in 1970, could not have been made available at the inception of the eradication scheme. One is left wondering whether it would have deterred some farmers from seeking qualification in the Accredited Herds Scheme.

(*b*) *Supervision of Pasteurizing Plants.*

There are 7 pasteurizing plants in the food and drugs area of the county and during the year 247 samples were taken for examination by the methylene blue reduction test (keeping quality) of which 8 failed. Of the 258 samples obtained for examination by the phosphatase test (efficiency of heat treatment), 2 failed. Investigations were carried out following the notification of failures.

These investigations include the inspection and rinse testing of surfaces, churns, bottles, and equipment generally. Where phosphatase test failures occur, investigations are made into the possibility of the admixture of raw with treated milk, the time/temperature relationship of treatment, and so on.

Detailed information which would indicate the reason for methylene blue failures in milk during distribution ((*c*) and (*d*) below) is not always available. So often these failures are due to over-keeping and not from any lack of hygiene in handling, processing, or bottling.

Date coding is not uniformly practical but where it is, efforts are made to check the " freshness " of the product at the point of retail sale.

(*c*) *Supervision of Dairies.*

There are 240 licenced distributors of milk within the food and drugs area of the county council. 260 samples of heat treated milk were subjected to the phosphatase test and there were no failures. 246 samples subjected to the methylene blue reduction test passed and 17 failed. 61 samples of sterilized and ultra heat treated milk passed the prescribed tests. These results, especially those indicating the efficiency of heat treatment, can be classed as satisfactory.

(*d*) *Milk in Schools Scheme.*

197 samples were taken during the year of which 8 failed the methylene blue or keeping quality test. 70 samples of canteen milk were also obtained and all of

these passed the phosphatase test while 1 failed the methylene blue test. Investigations followed all failures.

School Canteens.

There is close co-operation with the County Education Department in ensuring that the hygienic standards in school canteens are maintained at a high level. Exchange of information on methods, materials, equipment, etc., takes place constantly. Talks on food hygiene were given to gatherings of meals organizers and canteen staffs. This year special emphasis has been given to the materials and methods used to clean and sanitize work surfaces, equipment, and utensils. In connection with this, after extensive enquiries and trials, a code of practice was drawn up and distributed to all county council establishments. The code recommends a particular detergent and sanitizer combination and also an efficient general disinfectant. The correct use of these materials is described in the code.

Checks on the efficiency of the detergent sterilizer combination have been made and these have shown very satisfactory results.

It is often possible to report that no outbreaks of food poisoning have occurred in county schools. This year mention is made of a food poisoning incident which occurred at a junior school in which 87 children, teachers, and kitchen staff, suffered diarrhoea and sickness. On investigation it was revealed that the cook-in-charge had not complied with standing instructions about the preparation and consumption of meat in school canteens. Cooked minced pork was left in the kitchen overnight to cool and subsequently made into pork pies. The symptoms experienced were attributed to consumption of the pork pies. The cook was suspended from duty and subsequently resigned.

Swimming Pools.

The running and maintenance of the County's school pools to a satisfactory hygienic standard presents few problems. This is largely due to experience gained in the past and a continuous effort to standardize equipment, materials, and methods. Preliminary planning and consultation is especially necessary to ensure that pools sponsored by Parent Teacher Associations are satisfactory. In conjunction with the County Architect and County Education Officer, a brochure has been produced which guides schools executing this kind of project on county council standards. In addition to this, in cases where the school does not have suitable professional advice, the County Architect will give it.

During the year, in preparation for the 1971 season, a revised comprehensive operation and maintenance manual has been produced. Emphasis has been given to the translation of technical information into terms easily understood by laymen. This should simplify the task of teaching persons responsible for swimming pool operation.

A working party of the Department of the Environment has been set up to study the purification of swimming pool water and several meetings were held during the year. The County Health Inspector is a member of the Working Party. During the year 1,294 visits were paid to swimming pools by the health inspectors and sampling officers. Tests are carried out on site and advice given where necessary.

Refuse Disposal.

During the year, 5 consents for the disposal of non-putrescible material and 3 consents for the disposal of putrescible material were issued under the provisions of the Hertfordshire County Council Acts 1935 and 1960.

As has been mentioned in previous years, much of our work of supervising refuse tipping operations is concerned with the prevention of water pollution.

While the control of aesthetic standards may leave much to be desired, it is felt that the first priority must be to exclude the dumping of certain kinds of industrial waste which might, owing to the geological vulnerability of Hertfordshire mineral workings, cause pollution of underground water-bearing strata or surface streams. The problems of organic " leaching " are by now well known to us and we have had some cases of enrichment, or " eutrophication " as it is now fashionably called, in streams adjacent to putrescible refuse tips. While such enrichment might have undesirable aspects such as the creation of " fungus " of bacterial origin or the encouragement of " algal blooms " these can be regarded as of minor importance compared with the damage to water-bearing strata and streams should highly toxic, discolouring, or tainting chemicals gain access. Fortunately we have been able to continue our arrangements to have toxic industrial wastes received in a neighbouring county where there is comparative geological safety and a liaison group has been formed between the two counties to continue the study of toxic waste disposal. This is the kind of arrangement recommended in the report of the Technical Committee on the Disposal of Toxic Solid Wastes, a Committee set up by the Ministry of Housing and Local Government in 1964 and whose report was published in 1970. Hertfordshire was well represented on that Committee as both the County Medical Officer and the County Health Inspector were members. It is interesting that a system of licencing the transportation and final disposal of toxic wastes is advocated. The problem is so complex that any means whereby environmental risks can be reduced must be encouraged.

In my last report, I mentioned the problem of litter on the roads within the county, especially those which led to the large rubbish dumps which receive waste material from the Greater London Area. This problem is still manifest and a working party has been set up by the Clerk of the County Council which consists of officers representing both the county and district councils. This working party will continue to examine the problem in all its aspects.

Towards the end of the year, the services of the County Health Inspector were requested in a complex arbitration case involving land reclamation by tipping in South Africa. He was absent for one week and submitted evidence to the Court.

Gypsy Caravan Sites.

The running of caravan sites for gypsies was made the responsibility of the Health and Welfare Committee in 1964 and subsequent annual reports traced the trials and successes of what has become a considerable task. At the beginning of 1969, an assistant County Health Inspector was appointed with special duties involving the running of gypsy camps and the settling of " travellers ". With the separation of the social services from the health services, this work will pass to the newly formed Social Services Committee in 1971 and, therefore, this may be the last major reference to this work in a health report. The officer with special responsibility in this field will be transferred to the new Social Services Department and his original designation changed to that of County Adviser, Special Development.

The year began with the problem of making conditions acceptable and preventing nuisance on the two temporary encampments in St. Albans, one on land belonging to the county council and one on land belonging to the Ministry of Transport. The Health and Welfare Committee agreed to this course of action subject to the approval of the two district councils concerned. Negotiations broke down but it was arranged as a matter of urgency to provide minimal services at the sites as the conditions there had deteriorated and action was needed to prevent nuisance, risk to health, and to secure the safety of adjacent road users. Control was eventually established and the situation much improved. Nevertheless a case was heard before the St. Albans City Magistrates on 21st April when the city council prosecuted the county council for permitting

land at Cotlandswick to be used as a caravan site without there being in force a site licence. The county council pleaded guilty but despite a lengthy statement in mitigation of the problem the court saw fit to impose a fine of £75. It was understandable that the court felt obliged to apply the law the way they would to a private individual. Subsequently at an application by the city council for an abatement order in respect of the nuisance which was said to exist on the site, the court found that a nuisance had existed at the time the notice was served on the county council at the end of January but no nuisance existed then. In view of the possibility of it recurring, it was directed that an order should be made requiring some improvements and the presence on the site of a resident warden. It is regrettable that such conflicts between authorities should occur but they illustrate the intractable nature of the problems of dealing with gypsy families when they have nowhere they can legally stay. In discussion involving St. Albans city council and some members of the county council arising from the controversy of the presence of gypsies in the St. Albans area, the view had been expressed that the county council policy should be changed to include the provision of smaller sites than those recommended by the Ministry of Housing and Local Government, i.e. : sites of between 15 and 20 pitches. The recommendation was accepted by the county council that district councils be invited to submit any suggestions for small sites for consideration by the county council as a means of increasing the total capacity available and with the intent of introducing greater flexibility into the ways of dealing with the problem. A happy outcome was ensured by the St. Albans city council who offered two sites in the City for the establishment of small permanent caravan sites for gypsies.

On 1st April, 1970, the Minister of Housing and Local Government emphasized the need to spread fairly the burden of providing caravan sites for gypsies throughout England and Wales. It is thought that about 200 sites will ultimately be required. As a corollary in areas where sufficient sites have been provided (or cannot be reasonably provided) the Act gives local authority more effective powers to deal with unauthorized camping by gypsies. For both these purposes the gypsies are defined not by race but as persons of nomadic habit of life excluding travelling showmen or circus people travelling together as such. The definition makes no distinction between different groups of travellers or their trades. It covers Romanies, Diddycoys, mumpers, Irish tinkers, any of whom may be scrap metal dealers, tarmacadam workers, hawkers, etc. The major duty to provide sites is put on the county councils which are required to provide sites for all gypsies residing in or resorting to their area : the district councils have a duty to provide services and facilities and to manage the sites except that county district councils may relinquish these functions, their functions in this case being undertaken by the county councils. A summary of proposals received from local authorities by the Minister was distributed in November and indicated that at that time, between existing and proposed sites the total provision so far was 2,330 pitches on 158 sites. It was expected of councils that they would provide sites broadly on the pattern of the need established in March, 1965, with some additions to provide for increases since that time. The county council's programme submitted to the Minister is set out below :—

Existing sites.	*No. of families.*
Holwell Court, Cole Green, Hatfield (opened Easter, 1964)	15
Sandy Lane, Bushey (opened June, 1965)	27
* " Barbaraville " Mill Green, Hatfield (opened Autumn, 1964)	5
Sites not yet operating but for which deemed planning consent has been obtained.	
Smallford, St. Albans	15
Three Cherry Trees Lane, Hemel Hempstead.	15
Total	77

* This site is privately owned and run by the Cartland/Onslow Trust.

Future Overall Programme.

Three more sites are currently under investigation. Negotiations for the two sites, at Barley Mow Lane and Three Cherry Trees Lane, continue and the County Architect prepared a scheme which provided for 15 pitches on each. The pitch has a hard standing for caravan and towing vehicle and a small working area together with a small sanitary unit. Accommodation in the unit to be the minimum requirement for personal hygiene and general storage needs for the families. A community hut is to be provided in order that playgroups and educational activities can be held and the development of a community spirit encouraged. Both schemes were eventually approved. At the end of the year increasing problems of gypsy families camping haphazardly along main road verges drew attention to the need for the urgent implementation of the Caravan Sites Act, 1968, in all areas.

HEALTH EDUCATION.

Administration and Philosophy.

The following report has been prepared by the County Health Education officer :—

Two Health Education Officers and a Technician were appointed during the year, this demonstrated the importance which the department attaches to the role of its health education section. The result has been a rekindling of the section's enthusiasm and a new awareness of its potential contribution to the health and well being of the Community it serves. The allocation of health education officers to specific divisions has enabled the section to reach agencies and individuals previously inaccessible because of its lack in resources and manpower.

The one drawback has been the inadequacy of accommodation at Trevelyan House to contain the extra staff and activities. This difficulty will be partially relieved during 1971 when a re-allocation of space between the health education section and the district nurse training unit has been finalized.

The section has been attempting a re-appraisal of its future role against the changing background resulting from the creation of the Social Services Department, and the possible changes in the National Health Services administration. Changes are inevitable and the section has realized for some time that if health education is to have relevance to the emerging pathological patterns, i.e. behavioural diseases, then its intervention must be related to attitudes resulting in unhealthy behaviour, rather than in attacking established habits. This means that the section must retain close links with those social agencies which can create environments in which desirable attitudes are fostered. Hence the section has a significant part to play in demonstrating that the social, education, and health services are irrevocably linked by the needs of individuals and of the community. This is to say that " social education " is integral with " health education ". It is hoped that administrative divisions will not be allowed to preclude this concept.

Composition and Priorities of the Section.

With the return of Mr. I. C. Fairfax from the London University course, and the appointment of Mr. P. Pretty and Mrs. D. Tait as health education officers, and Mr. R. Phillips as the audio-visual aids technician, the section was considerably strengthened in the latter part of the year. It is now able to call on many fields of experience related to health, education, and communications.

The allocation of officers to divisions has gone ahead. Each division offers a different kind of challenge to which the officers must adapt according to their particular situation. This adaptation, however, is within the context of certain

central principles evolved from regular staff meetings and discussions, from which it is hoped eventually to produce a common concept and approach to health education, acceptable throughout the department. The support and resources of attached health education officers has enabled divisional medical officers to widen their involvement in health education.

Priorities for the sections present and future involvement have not been easy to define, but some are discussed below.

Drugs and Other Addictions.

The problem of drug abuse, although still with us, has lost its aura of crisis. We have taken the opportunity of this "lull" to press for an "on going" educational approach to drug use and drug abuse in society, rather than the short term dramatic approach, which may possibly have been justified during the apparent crisis period. The section has concentrated on arranging seminars for teachers and talks to parent teacher associations. During these sessions the opportunity is taken to challenge the subjective attitudes of our audiences towards the problem. We are also attempting to make people think of addiction in more general and yet more personal terms, i.e., tobacco, alcohol, prescribed medicines, etc., and to consider their own involvement, rather than give the impression that only certain groups have a drugs problem. This approach is interpreted by other agencies on occasions as a radical one.

Education for Personal Relationships.

This is a phrase which is gaining in popularity. It is interpreted in many ways and often misconstrued as sex education. A comprehensive and sensitive approach to this type of education is seen by the section as vital, long term aspect of health education directed to all age and social groups.

Smoking.

We have been much concerned by the neglect of health education generally to take account of the sociological evidence on the reasons why people smoke. Most agencies appear to be restricted to a short term propaganda approach which has largely been discredited by research evidence. However, the concept of simplifying the smoking problem to one of persuading people to give it up, plus the constant attention given to it by the mass media appears to be having an effect.

Venereal Disease.

This is an involved problem which is being tackled without a basis of sound research knowledge. The recent upsurge in gonorrhoea, may in part, be a rebound to our basic message "that V.D. can be cured" in that the promise of a cure makes the risk of infection less onerous.

The use of the V.D. telephone answering service in South West Division on V.D. is proving a most successful health information experiment, which could be extended to other divisions and deal with other topics.

Illegitimacy.

There is tendency to see this problem as one of support for unmarried mothers and/or successful adoption. The potential of health education in preventing the problem is yet to be appreciated.

Mental Health.

The possible promotion of mental health and the prevention of mental ill-health by health education is a subject that has exercised the section a great deal. As yet most of our activity has been related to the acceptance of the mentally ill and handicapped in the community.

Ethnic Groups.

The Section feels that more research into the health education needs of the ethnic groups now settled in the county is required and will be looking into this in the future.

The Physically Handicapped.

These are forming into a group with definite health education needs and the section is concerned to gather information leading to an approach which will meet these needs.

The general theme running through these specific priorities is the need for a radical change in attitudes to, and expectations from, health education. In Hertfordshire we have the resources to undertake a confident and positive approach to health problems. We may make mistakes in covering new ground, but this must be preferable to an assumption that our society is so imperfect that all we can do is wait for problems to arise and meet them on an *ad hoc* basis. We have the research resources which, if properly used, could anticipate and abort hazards to health and well-being before they manifest themselves as pathological entities.

Activities of Health Education Officers.

The routine functions of the officers related to the support and in-service training given to the department's field staff continued, as it did for other groups in the county. There was a noticeable upsurge of interest in the creation and use of display material following a two-weeks exhibition and conference for health visitors held, in conjunction with the Health Education Council during March.

In February and March, we had visits to three divisions by the mobile unit of the Health Education Council. A good deal was learned about the use of this very sophisticated technique for informing large sections of the population in particular health topics. By siting the vehicle in different locations in three towns and noting the public's response, we were able to assess what could well be an important health education medium.

Contacts made by health education officers include most types of educational establishments, accident prevention committees, social work agencies, religious bodies, citizens advice bureaux, industrial concerns, voluntary societies, hospitals, and general practitioners.

There are encouraging instances of interest in health education by general practitioners. We hope that we may be able to stimulate this interest in the future.

For obvious reasons we attach great importance to our contacts and influence in the formal educational system, i.e., schools, colleges, and teachers centres. We feel we have made significant strides towards achieving an understanding of our respective professional roles at all levels. We look forward to even greater co-operation in the future.

Our initial contacts with hospitals have been very cordial. Generally, however, we find that hospitals have yet to be convinced of the very vital part they can play in the overall schemes of health education.

Our contacts with industrial concerns have not been widespread, but the willingness of concerns, not only to co-operate in general, health education, but to call in our officers as advisers, demands that we must take every opportunity of increasing these contacts.

There is much work that can and should be done. By and large, the section is confident that it can meet the challenge.

PAPER PRESENTED AT INTERNATIONAL CONGRESS OF PSYCHOSOMATIC MEDICINE IN OBSTETRICS AND GYNAECOLOGY, LONDON, MARCH, 1971.

SEX EDUCATION.

GODFREY D. RIPLEY.

The author has suggested elsewhere [1] that the provision of a meaningful course on human relationships within a Health Education programme in the school setting might help reduce the currently recognized increasing incidence of adolescent psychosomatic morbidity [2] and depression,[3] increasing incidence of drug dependence in young people[4,5] and juvenile venereal disease[6,7,8] and the increase in the unmarried conception rate in young girls.[3,9,10] The Chief Medical Officer of the Department of Health and Social Security has stated [8] that the prime objective in the campaign against the rising incidence of venereal disease must be education on the risks of promiscuity. And in what setting is education carried out with more facility than that of the school ?

This paper presents a practical application of this programme with particular reference to the provision of sex education. Its aim is an attempt to reduce the aforementioned morbidity by giving young people some measure of understanding of the mainstreams of human interaction and their motives. That the programme is given by a doctor who is also a physician within the community, in the author's view, gives greater credence to its content. The role of the doctor here is one of teacher—the emphasis on the concept of health.

Boreham Wood is a town of approximately 30,000, 20 miles from London at the southern edge of Hertfordshire. It has 5 secondary schools and the author, who is a general practitioner in a group practice, teaches at 3 of these. He attends each once weekly, taking a class for a school term. The children are between 11 and 14—the classes mixed both regards sex and ability, the doctor being accepted as a regular member of the school teaching team.

The syllabus covered is shown in the Appendix, depth of presentation being adjusted to the chronological age and emotional development of the major part of each group. The sessions are carried on in as informal a way as possible and are started by introducing the subject as Human Relationships. The pupils are invited to give their definition of this term and opportunity is given for discussing its full significance.

On the biological plane, cellular anatomy is discussed and basic genetics introduced. The concept of behaviour is studied on the functional plane, with its motives and emotional components. The relationship of the individual to his environment, human interaction and the concept of interpersonal relationships are studied. The significance of the aphorism " nature and nurture " is established.

Human growth and primary sex differences are studied. The changes of puberty are introduced with the corresponding secondary sexual features. The development of adolescent and adult behaviour is viewed alongside the growth of adult sexuality. The forms this takes are noted and sexual anatomy and physiology studied.

That emotions are involved is stressed—the meaning of pleasure and its significance with regards behaviour discussed. The place of masturbation is considered and sexual technique in love-making studied.

The concept of fertility control is introduced—and pregnancy, the family, and illegitimacy discussed. Contraception is introduced, the different methods described and compared, samples being shown where applicable. Male and female sterilization are described and abortion discussed. The sexually transmitted diseases, notably gonorrhoea, syphilis, non-specific urethritis and pediculosis pubis, are described and their epidemiology discussed. The meaning

of promiscuity is studied and an attempt is made to understand its significance *vis-à-vis* the concept of " love ".

The course continues to cover the mainstreams of human interaction and introduces discussion on homosexuality, drugs, smoking, and alcohol—and opportunities exist for follow-up in the sixth form in at least one of the schools.

Wherever possible, integration is aimed with other subjects, e.g. geography and history teachers can follow with discussions on world population problems.

This teaching programme is non-moralistic in the accepted meaning. Rather, it attempts to provide a measure of understanding for actions and their motives—so that the young person can make a realistic appraisal on which to base judgement for his own individual decision—whether he should, or should not—and why? To allow him to develop and discover his own code of conduct in relation to his fellow man and fellow woman.

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APPENDIX.

HUMAN RELATIONSHIPS—SYLLABUS.

Interaction.

1. Biological.

The cell	Anatomy.
Genetics	Genes—elements of theory—environment.
Growth and development .	Fertilization.
	Nutrition.
	Intra-uterine life.
	Maternal environment (e.g. disease).
	Birth.
	Primary sex characteristics
	Elements of anatomy and physiology.
	Baby and infant development.
	Endocrine system and hormones.
	Puberty.
	Secondary sex characteristics.
	Menstruation.
	Sexual maturation.
	Coitus.
	Pregnancy.
2. Sociological . . .	Social maturation.
	Courtship.
	Love making.
	Fertility control.
	Sexually transmitted diseases.
	Marriage.
	The family (compare alternative systems).
	Illegitimacy.
	Abortion.
3. Ethological.	
A. Personal identity . .	Ontology.
	Emotional pressures—needs for gratification.
	Instinct and environment.
	Conflict.
	Aggression
	Anxiety—Frustration—Pain.
	Comfort habits } masturbation—
	Displacements } drugs, alcohol, smoking
	Interpersonal relationships.
	Authority—Peers.
	Pair formation.
	Sex role—heterosexuality and homosexuality.
B. Social identity . .	Ethics—code of conduct—moral code.
	Decision making.
	Sexual patterns and courtship.
	Family—abortion—adoption.
	Social services.
	Current social problems (e.g. "Test-tube babies")
	Death.

RESEARCH PANEL.

Research is one of the functions of a local health authority but this is usually one which is less well organized and planned than other services.

Apart from the routine operational research, which is necessary to determine whether existing services are meeting the changing needs of the community, there are also many opportunities of studying the changing trends in mortality and morbidity.

A research panel was formed in 1963 to initiate and stimulate research within the department, made up of interested medical and other staff from headquarters and divisions and from field staff with a particular flair for research. A statistician was appointed to act as technical officer. In addition, the panel was strengthened by the inclusion of a consultant geriatrician, a psychologist from The Hatfield Polytechnic, a general practitioner, and the health visitor tutor from Stevenage College of Further Education. There have been four chairmen of the panel since its inception, Drs. Cust, Allen, and Burns, and the present chairman Dr. F. Seymour, 2nd Deputy County Medical Officer.

Members of the panel interested in carrying out a particular field of study present their ideas in writing to the panel where free discussions ensue with the aim of improving or augmenting the study. The leader of the project then acts as chairman of a small working party where detailed consideration is given to all aspects of the research project. Two courses in research methods, each lasting approximately 10 weeks, have been organized at Hatfield College where the panel members were given training in the methodology of research.

Research projects which have been considered by the panel include the following. 8 have already been accepted for publication in the appropriate medical or other journals and a further 3 are in the process of being published.

No.	*Project.*	*Brief description.*
64/1	Immunization reaction after triple immunization	Trial of vaccines with Glaxo, Ltd.
64/2	Physically handicapped school leavers	To investigate how severely handicapped young persons managed after leaving school.
64/3	Normal developmental processes in young babies	To study specific milestones to assess their reliability and variability.
64/4	Effects of early discharges from maternity units . . .	To determine whether the system of early discharge renders the mother or child more liable to medical or other complications.
64/5	Work of health visitors first survey	Inquiry into work of health visitors ; (*a*) attached to G.P.s (*b*) working in geographical areas.
64/6	Para 3+ mothers having babies at home	To investigate the reasons why mothers of para 3+ elected to be delivered at home and the effects of this choice.
64/8	Staff medical examinations . .	To relate subsequent absences on sick leave to declaration of medical fitness on appointment.
64/9	Physical fitness index . . .	To relate physique to mental agility.
65/1	Diabetes survey	(*a*) An opinion survey of patients attending a G.P.s surgery ; (*b*) a pilot detection survey in a general practice.
65/2	Congenital abnormalities . .	Investigation of incidence of talipes and spina bifida.
65/3	Plantar Wart Prevalence survey .	To discover the prevalence of plantar warts and to relate these to bare-foot and swimming pool activities.
65/4	Work of social workers . .	Inquiry into work of social workers to ascertain details of case loads.
65/6	Crossed laterality and slow reading	Relationship between crossed laterality and behaviour problems in schoolchildren.
66/1	Smoking survey	Follow-up of effects of health education on smoking habits.

No.	*Project.*	*Brief description.*
66/3	Screening procedures in general practice	Record and assessment of screening procedures in general practice.
66/4	Assessment of latent diseases in the elderly	To detect treatable disease in the elderly at an early stage.
66/5	Health education in schools . .	To ascertain gaps in health education teaching in schools.
66/6	Plantar Wart treatment trial .	To compare methods of treatment of plantar warts.
66/8	Work of health visitors, second survey	Inquiry into work of health visitors—effects of attachment.
66/9	" At Risk " Registers . . .	To determine categories to be included in " at risk " registers.
66/10	Heart murmurs in school children.	To ascertain what heart murmurs should be recorded by ACMOs.
66/11	The work of an assistant County Medical Officer. . . .	Assessment of functions and role of ACMOs.
67/1	Remedial teachers . . .	Experiment at Stevenage A.T.C. on effects of remedial teaching.
67/3	I.Q. and gainful employment .	Survey to determine whether a factor other than I.Q. influences the ability of an E.S.N. leaver to obtain gainful employment.
67/4	Smallpox vaccination and plaster reaction	To obtain a more efficient means of preventing infection after vaccination.
67/5	Sex education.	To assess the adequacy of sex education in schools.
67/6	Nutritional survey . . .	Survey in Old People's Homes comparing frozen foods with conventional foods.
67/7	Breast cancer	To measure effectiveness of health education methods to persuade women (*a*) to undertake self examination ; and (*b*) to consult their doctor about lumps discovered.
68/1	Identification of health education needs	To put health education on to a more scientific basis and to employ resources where most needed.
68/2	Mental health week . . .	To discover attitudes and knowledge and to feed information in an attempt to alter attitudes.
68/3	Influenza study . . .	To assess the degree of protection afforded by influenza immunization in old persons' homes.
68/4	Programmed learning centre.	—
68/5	Maternity and Infant Care Association. Investigation into Maternity Services	A survey undertaken in association with M.I.C.A. (Maternity and Infant Care Association) to discover attitudes towards the maternity services provided by hospital and local health authority staffs
68/6	Survey of young chronic sick.	Pilot survey being undertaken in Boreham Wood.
68/8	Work Study for nurses. .	Enquiry into work of all nurses and health visitors employed in the County.
68/9	Dental Health Campaign .	Assessment of value of dental health campaign.
68/10	Accidental hypothermia .	Socio/medical investigation of persons admitted to hospital with accidental hypothermia.
69/2	Follow-up of residents discharged from Spring House (Mental Health Hostel) Welwyn Garden City.	
70/1	Survey of population attitudes and habits towards medicines in the Home.	Leader Mr. Evans. Initially before Panel : 8th July, 1970

Although the projects do not always come to fruition, the existence of a research panel in the department has given great encouragement to the staff to adopt a critical approach to the work they are undertaking for this is vital if we are to make the best use of highly-trained officers who are in short supply.

PART II—SOCIAL WELFARE SERVICES.

County Social Work Supervisor's Report.

At the end of 1970 social workers in the 6 divisional social work units were preparing for a further extensive change, that of integration with colleagues of the Children's Department into the new Social Services Department, i.e., anticipating the coming into operation of the Local Authority Social Services Act, 1970. During the year more social workers were employed so that at the year end there were 100, some of them part-time, approximating, on a full-time basis, 1 per 10,000 of the population, still not enough when of that number 15 were away on professional courses. Since the Department was established in 1965, the number of professionally qualified social workers employed has risen from 8 out of 46 to more than 60 out of 100 and the ratio is increasing. Soon, most of the staff will be qualified except for trainees and graduate trainees whom we need to bring fresh ideas into the department. They will be sent for professional training after a period of induction. These figures are as good as any in the country and indicate the advancement made in the past 5 years.

At the end of the year Dr. Torrie retired. For many years he had been the department's consultant psychiatrist and guide, philosopher and friend to many social workers in the mental health section and later in the combined social work section of the Health and Welfare Department. He and Miss Thomas, who retired earlier, put down solid roots from which professional work in the department was able to grow. We also heard at the end of the year that Mr. Jones would be leaving the Mid-Herts unit to become Director of Social Services in Chester. Other divisional social workers are preparing to leave for Assistant Director posts. Out of 8 divisional social workers employed since 1965, we have produced 1 Director, 1 Deputy, 1 Central Government Welfare Officer, 2 Assistant Directors, 1 Principal, 2 divisional social services officers which endorses our appointment of good leaders, fundamental to good social work management.

Social workers were concerned with over 9,000 clients in 1970 ; more than an average of 100 each. There were more than 50,000 interviews and of the 9,000 clients afforded a professional social work service about 2,000 were elderly, 1,500 physically handicapped, 1,500 mentally ill, 1,000 subnormal, 2,000 blind or partially sighted. 1,000 clients were seen for various other reasons including marital problems. Workloads were beginning to diminish but were still too high.

In-service training has now developed so that every member of staff has an opportunity to join a group to develop his understanding and skill. This year, for the first time, I was able to start an in-service training course for 5 young trainees all at about the same level and next year I hope it will be possible to have a group of trainees aged around 19, or young people who are social science graduates. The groups in 1970 were beginning to broaden. For example, Miss Meadows, a community worker from Hemel Hempstead, took a group on youth and community work and Miss Sheila Sturton from Mid-Herts extended her functions in group work. These were mixed groups on psychiatry, family social work, consultation, and general matters. The department continues to offer supervision and practical work experience to a wide range of students who come from a broader variety of training courses now that we can offer, for example, placements in group work with Miss Sturton in Mid-Herts. We are also beginning to take management students from the National Institute and other courses. We are developing work with young people on a detached basis in Stevenage and Mid-Herts and there will be further opportunities for students once these projects are fully established.

During the last five years a new concept in social work has gradually emerged in this and some other authorities. We have discovered that by putting together social workers, the client benefits once the initial integration period is over. This takes time and the new Social Services Department will find that it

will take a further period of time to complete the processes of integration. We have discovered that by offering common training and group experiences to staff the process of integration is speeded up. Research which we have not been able to carry out as much as we would like is another way of clarifying what is happening and the information can be used to accelerate the process of becoming a more efficient Department.

MENTAL HEALTH.

The steady growth of the community care and mental health service over the past decade continued during 1970 as shown in the following table giving the numbers at 31st December, 1961, 1969, and 1970 :—

Description.	*1961.*	*1969.*	*1970.*
Mentally disordered persons in community care	1,144	2,728	2,986
Attending training centres	263	875	922
In residential accommodation	21	212	248

An extension to the Watling View Junior Training Centre, St. Albans, to provide 2 additional classrooms was completed during the year. Geddings Adult Training Centre, Hoddesdon, providing 100 places, was completed at the end of the year and arrangements made for the trainees to transfer there at the beginning of 1971 from the centres previously held in the Civil Defence Huts in Hertford and Ware. A major extension was in course of erection at the Amwell View Junior Training Centre, Stanstead Abbots to provide additional classroom accommodation and improve dining, assembly, and kitchen facilities.

There were no completed capital developments in the Mental Health Hostel field during the year but two major projects were nearing completion, i.e., conversion of Rowneybury, Sawbridgeworth for use as a 21 place hostel for severely subnormal children and the building of Horseshoe Lodge, Garston, a 26 place hostel for the mentally ill. Minor works were also nearing completion in 2 houses in Hemel Hempstead and Letchworth which are to be used as unstaffed mental health hostels.

The recruitment and retention of staff in the training centres and mental health hostels continued to present problems although it was usually possible to recruit staff for vacancies as they occurred but rarely by persons with the appropriate qualifications for the subordinate posts. The authority continued to pursue a very active policy in the training of staff.

10 training centre staff completed full-time 1- or 2-year courses in July, 1970, 7 commenced full-time courses in September, 1970, and arrangements were in hand for a further 8 staff to be seconded to full-time courses commencing in September, 1971. In addition to these full-time courses, staff were seconded to a number of part-time courses.

Community Care.

At the end of 1970 there were 2,986 cases in community care, consisting of 1,697 subnormal and 1,289 mentally ill persons. During the year 845 mentally ill and 193 subnormal were referred for community care under the Mental Health Service. The sources of referral were as follows :—

Source of referral	*Mentally ill.*	*Subnormal*	*Total.*
General practitioners	230	3	233
Hospitals, following in-patient treatment	150	43	193
Hospital out-patient departments	178	5	183
Local Education Authority	4	22	26
Police and courts	17	—	17
Other sources	266	120	386
Totals	845	193	1,038

Training Centres.

At the end of the year 876 Herts mentally disordered persons were attending training centres as follows :—

Attending.	*Mentally ill.*	*Subnormal.* *Under 16.*	*Over 16.*	*Total.*
Herts C.C. Centres . .	31	403	420	854
Other Authorities' Centres .	7	4	11	22
Totals	38	407	431	876

In addition a further 46 persons were attending Hertfordshire training centres at the end of the year—43 physically handicapped persons ordinarily resident in Hertfordshire and 3 subnormal cases who were the responsibility of other local authorities. There were 11 cases awaiting admission to centres and arrangements were in hand for all to commence attendance in early 1971.

Residential Accommodation.

During 1970, 308 mentally disordered persons were maintained in hostel accommodation and of this number 241 were still away at the end of the year. In addition, 12 out-County cases were accommodated during 1970 in the authority's hostels of whom 7 were still in residence at the end of the year. The breakdown of the Herts cases is shown in the following table :—

TABLE 22.

	Subnormal. *Under 16.*	*16 and over.*	*Mentally ill.*	*Total.*
1. Herts cases maintained in 1970 :—				
(*a*) Herts C.C. Hostels . .	20	85	54	159
(*b*) Other Homes and Hostels .	41	61	47	149
Totals	61	146	101	308
2. Herts cases still in residence at 31.12.70 :—				
(*a*) Herts C.C. Hostels . . .	20	66	34	120
(*b*) Other Homes and Hostels .	39	56	26	121
Totals	59	122	60	241

(*b*) *Short Term.*

Arrangements were also made during the year for 84 cases to be placed for periods of short-term care. Of these, 19 were placed in the authority's Hostels and 65 in voluntary and private homes.

Social Clubs.

There were 26 social clubs for mentally disordered persons meeting regularly at the end of the year including a number organized by voluntary organizations and in appropriate cases grants were made by the county council towards their running expenses.

Admissions to Hospital.

(*a*) *Mentally Subnormal.*

The greater part of Hertfordshire is in the catchment area of Cell Barnes Hospital, St. Albans, the remaining areas being East Herts, which is served by South Ockenden Hospital, and Royston which is in the catchment for Ida Darwin Hospital, Cambridge.

39 subnormal patients were admitted to hospital during 1970 (11 children and 28 adults). In 11 cases the patients were detained under the Mental Health Act, 1959, and the remaining 28 were admitted informally.

In addition to the admissions for long term care, 98 patients were admitted to hospitals for the subnormal for short-term care during the year.

The local authority continued to maintain a waiting list of subnormal persons requiring long-term hospital care and at the end of the year there were 20 children and 7 adults awaiting admission.

(*b*) *Mentally Ill.*

The catchment area of the psychiatric hospitals serving the county remained unchanged.

During the year 484 mentally ill persons were admitted to hospital as either statutory or informal patients following action by a mental welfare officer, compared with 506 patients in the previous year and 422 in 1968.

The number of actions taken show a slight decrease on the previous year. 90 persons were admitted to hospital informally compared with 92 in the previous year, and the number of emergency admissions under Section 29 of the Mental Health Act, 1959, rose from 257 to 273 whilst the numbers admitted under Sections 25 and 26 fell from 287 to 254. Under these latter sections the need for admission to hospital is confirmed by 2 medical practitioners, 1 having special experience in the diagnosis or treatment of mental disorder.

Appendix.

In the following table (no. 23) comparative figures are given on various aspects of the mental health service during the past 6 years as at 31st December. This is followed by Table 24 which gives details of the number of persons being helped under the mental health service at 31st December, 1970, divided into the various types of services and also categories of mental disorder and the age and sex distribution.

TABLE 23.—COMPARATIVE FIGURES.

	1965.	*1966.*	*1967.*	*1968.*	*1969.*	*1969.*
These figures relate to numbers dealt with throughout the year.						
Temporary admissions, to relieve families, in year.						
(*a*) to hospitals	84	84	100	135	81	98
(*b*) elsewhere	19	38	32	47	60	84
New referrals for community care in year.						
Mentally ill	352	501	653	707	848	845
Mentally subnormal	232	263	278	273	209	193
	584	764	931	980	1,057	1,038
These figures relate to the numbers "active" at 31st December.						
Numbers receiving community care.						
Mentally ill	317	391	556	597	1,121	1,289
Mentally subnormal	1,150	1,314	1,446	1,546	1,607	1,697
	1,467	1,705	2,002	2,143	2,728	2,986
Numbers in residential accommodation						
Mentally ill	15	10	20	29	57	60
Mentally subnormal	66	83	116	128	146	181
Numbers receiving training and hospital waiting list						
Attending training centres	534	621	748	802	875	922
Receiving home training	17	25	26	20	14	7
Subnormal hospital waiting list	49	44	45	36	20	27

TABLE 24.—NUMBER OF PERSONS UNDER LOCAL HEALTH AUTHORITY CARE AT 31ST DECEMBER, 1970.

	Mentally ill				Elderly mentally infirm		Psychopathic				Mentally handicapped				Severely mentally handicapped				Total
	Under 16		16 & over				Under 16		16 & over		Under 16		16 & over		Under 16		16 & over		
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)
1. Total number	—	—	389	766	35	99	—	—	1	1	—	1	421	294	278	229	226	246	2,986
2. Attending workshops, day centres, or training centres (including special units)	—	—	12	14	4	8	—	—	1	—	—	—	70	64	220	187	136	155	871
3. Awaiting entry to workshops, day centres, or training centres (including special units)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	7	4	—	—	11
4. Receiving home training	—	—	4	1	—	—	—	—	—	—	—	—	1	—	—	—	—	1	7
5. Awaiting home training	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
6. Resident in L.A. home/hostel	—	—	14	22	—	—	—	—	—	—	—	—	24	20	10	10	6	16	122
7. Awaiting residence in L.A. home/hostel	—	—	2	1	—	—	—	—	—	—	—	—	3	2	6	4	2	2	22
8. Resident in other home/hostel	—	—	12	9	—	1	—	—	—	—	—	—	8	10	25	14	10	16	105
9. Boarded out in private household	—	—	1	1	—	—	—	—	—	—	—	—	1	2	—	—	4	5	14
10. Attending day hospital			7	19	—	3	—	—	—	—	—	—	—	—	—	—	—	—	29
11. Receiving home visits and not included in items 2–10 :—																			
(*a*) Suitable to attend a training centre	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
(*b*) Others	—	—	342	703	31	87	—	—	—	1	—	1	323	211	27	26	79	72	1,903

BLIND PERSONS.

The Hertfordshire Society for the Blind has continued to provide voluntary services for all visually handicapped persons resident in the county. These services are intended to supplement those provided by the local authority ; the need for close liaison between statutory and voluntary bodies being fully recognized. The Aves' Report which has recently been published emphasizes the fact that the volunteer can fulfil a useful role in the field of social service. The national shortage of professionally trained social workers underlines the need for voluntary help in all branches of services for the handicapped.

The Society organized an " Information Day " meeting in St. Albans in the early part of the year : the aim being to recruit volunteers and consider ways in which the Society could expand its services. The response to the invitations sent to individuals and members of other organizations was encouraging. The speakers were the County Welfare Officer, a Divisional Social Worker and a registered blind person ; the talks illustrated the link between the social services at county level with those in the field, and the reactions of the client to both. There was a lively discussion at the end of each session and one result of the meeting is that a local group has been set up in one division to undertake work among elderly, blind housebound persons. It is hoped that as time goes on more volunteers will come forward to assist in this way thus leaving the professional social worker with more time to deal with the needs of those who require specialized services.

Day Centre.

The Society administers a social centre for the blind at Hemel Hempstead which is used for social and diversional activities. During the year it has been possible to increase the use made of the building and weekly sessions are held for blind and physically handicapped persons, the mentally handicapped, and other group activities all of which have been arranged with the approval of the county council.

Mobility Training.

The appointment of a mobility officer by the department has been welcomed by the Society who readily agreed to assist by paying the training fees. It is hoped that the instructor will complete the course in March and it will then be possible to plan the setting up of centres within the county for the purpose of instructing blind persons in the new technique of mobility based on the use of the long cane.

St. Audrey's Home for the Blind.

The Society continues to administer this residential Home which can accommodate 29 blind men and women. The average age of the residents is 80 years and many of them are physically frail in addition to the visual handicap.

Statutory Register.

It is a statutory duty of the local authority to keep a register of all blind and partially sighted persons resident in the area.

The number of blind persons on the register was 1,595, a decrease of 5 over the previous year. The age groups of all those on the register are given in Table 27 : the upward trend continues as the majority are over the age of 65 years.

The number of children whose only handicap is a visual one is 19, but children with additional handicaps number 26.

It is of great importance that parents of visually handicapped children are given the utmost support and advice in the care and management of the child as early as possible. Most parents have problems of one sort or another when faced

with the task of bringing up a handicapped child. In order to assist with this problem a parent's group has been formed in Dacorum Division. The sessions are held bi-monthly and the discussions which take place are constructive and mutually helpful.

TABLE 25.—CLASSIFICATION OF BLIND REGISTER.

	1970.	*1969.*
Children under 5 years	9	13
Children 5–15 years	36	34
At school 16–20 years	3	3
Trainees	12	12
Employed in special workshops for the blind	2	2
Employed in approved Home Workers' Schemes	17	18
Employed under ordinary conditions	186	174
Unemployed—available for and capable of work	13	28
Not available for work	145	132
Not capable of work	97	94
Aged over 65 years	1,075	1,090
Totals	1,595	1,600

Wireless Licences.

The department issued 108 certificates during the year to enable blind persons to obtain a wireless receiving licence without payment of the usual fee.

There is no statutory definition of partial sight but where the visual handicap is likely to be of a permanent nature although the residual vision is above the level required for blind registration a person may be registered as partially sighted : in many cases the prognosis is that blindness may occur at a later stage : such persons will therefore require many of the welfare services available to blind persons.

The number of partially sighted persons on the register at 31st December, 1970, was 510 : this represents an increase of 23 over the previous year. The age groups of the partially sighted register are given in Table 28.

TABLE 26.—CLASSIFICATION OF THE PARTIALLY SIGHTED REGISTER.

	1970.	*1969.*
Children under 5 years	2	3
Children 5–15 years attending special schools	20	19
Children 5–15 years attending other schools	24	21
Children 5–15 years not at school	3	5
Children 5–15 years unsuitable for education at school	1	2
At school 16–20 years	4	4
Trainees	8	9
Employed persons	98	101
Unemployed—available for work	15	16
Aged 65 years	335	307
Totals	510	487

TABLE 27.—AGE GROUPS OF REGISTERED BLIND PERSONS.

Years	Under 1	1	2	3	4	5-10	11-15	16-20	21-29	30-39	40-49	50-59	60-64	65-69	70-74	75-79	80-84	85-89	90 and over	Un-known	Total
Males .	—	1	1	3	2	17	6	9	26	40	56	73	38	50	66	67	67	41	32	—	595
Females	—	1	1	1	—	7	5	7	20	22	41	62	64	71	88	131	173	166	139	1	1,000
Total .	—	2	2	4	2	24	11	16	46	62	97	135	102	121	154	198	240	207	171	1	1,595

TABLE 28.—AGE GROUPS OF REGISTERED PARTIALLY SIGHTED PERSONS.

Years	0–1	2–4	5–15	16–20	21–49	50–64	65 and over	Unknown	Total
Males . .	1	2	29	14	51	28	64	1	190
Females . .	—	—	18	19	39	27	217	—	320
Total . .	1	2	47	33	90	55	281	1	510

THE DEAF.

Welfare Services for the Deaf are undertaken on behalf of the county council by the St. Albans Diocesan Association for the Deaf who also act as agents for Bedfordshire County Council and the County Borough of Luton, each authority making a grant towards the association's administrative expenses on a percentage basis.

The Association employ six welfare officers who work in close co-operation with the county council social work units, and who assist their deaf clients with their social problems, helping them to try to overcome the difficulties caused by the lack of communication with the hearing person, by acting as interpreter at interviews with prospective employers, at hospitals, at doctor's surgeries, or in court. In addition Association staff assist and encourage the deaf in the formation of social clubs and similar activities. On 31st October, 1970, there were 413 registered deaf persons in the county their age and distribution being as follows. Last year's figures are shown in parentheses.

TABLE 29.

Age Group	Deaf without Speech		Deaf with Speech		Total
	Men	Women	Men	Women	
0–15 . .	23 (23)	16(22)	15 (13)	16 (19)	72 (77)
16–64 . .	65 (68)	71 (67)	65 (52)	67 (55)	268 (242)
65 plus . .	9 (9)	15 (15)	13 (15)	36 (34)	73 (73)
Total :	99 (100)	104 (102)	93 (80)	119 (108)	413 (392)

THE HARD OF HEARING.

The hard of hearing are those, who with or without a hearing aid have some useful hearing, and whose normal method of communication is by speech and listening or by lip reading.

The social and recreational facilities for this group are provided throughout the County by voluntary groups who with the exception of the Potters Bar group are affiliated to the Hertfordshire League for the Hard of Hearing. The Potters Bar group remains attached to the Middlesex and Surrey League.

The County Council makes a grant towards the League's administrative expenses.

At the end of the year there were 251 hard of hearing persons registered within the County.

WELFARE OF THE HANDICAPPED (General Classes).

Although the long awaited report of the Government's Social survey on the handicapped in Great Britain has not yet been published, an important piece of legislation which was introduced in 1970 was the Chronically Sick and Disabled Persons Act. Although from this department's point of view the Act merely repeated the services which we already provided under Section 29 of the National Assistance Act, 1948, it also dealt with such important aspects as research and development of aid and equipment for the handicapped, the involvement of the handicapped themselves on advisory committees dealing with services for the handicapped, the special education of handicapped children, the provision of housing for the handicapped, and facilities for access to public buildings, etc. Not all the sections of the Act were operative by the end of 1970, the most important one from this department's point of view, which is yet to be implemented being section 1 requiring the local authority to find out the number of handicapped persons within their area and to inform them of the various services available. An accurate knowledge of the numbers of handicapped and of their needs is, of course, vital in the planning of future services for the disabled.

In the meantime as can be seen from Table 30 the number of registered handicapped persons continues to increase and as a result there has been greater demand on resources.

TABLE 30.

	1965.	*1966.*	*1967.*	*1968.*	*1969.*	*1970.*
Under 16 years . . .	107	76	82	87	95	105
Aged 16–64 years . .	1,089	1,244	1,386	1,514	1,667	1,826
Aged 65 years and over	961	1,065	1,298	1,428	1,637	1,880
Total .	2,157	2,385	2,766	3,029	3,399	3,811

The needs of the handicapped are naturally varied and to a large extent are dependent on the individuals ability. To help these needs the county council uses the services of many voluntary organizations but employs as its main agent the Hertfordshire Association for the Welfare of the Handicapped which keeps in contact with the handicapped through its district and area committees to arrange outings, social clubs, home visiting, holidays, and run work centres which the handicapped who are not capable of open or sheltered employment may attend on one or more days per week, to undertake factory outwork. During 1970, a further such centre was opened at Oxhey and extensions to the St. Albans centre were carried out.

When the handicapped person requires more skilled help and advice than would normally be expected to be given by voluntary workers, arrangements are made for their needs to be referred to the appropriate social work unit. One of the services which continued to occupy much of the specialist social workers time was the adaptations of house occupied by handicapped persons and the number of home adaptations during the year showed a further increase to 176.

CARE OF THE ELDERLY.

The elderly person's desire to remain in his or her home as long as possible coupled with the increasing number of elderly in the county has resulted in still further demand on the domiciliary services.

Day centre activities were increased with the establishment of further centres throughout the county and plans were under way for these activities to be still further extended during 1971. The problem of conveying the elderly to these centres persisted as a result of which the Committee agreed to the principle that each division should be provided with a specially adapted vehicle. It was hoped that all or some of these vehicles would be available during the first half of 1971.

To help maintain an elderly person within the community demands close co-operation between the statutory and voluntary organizations and once again tribute must be paid to the amount of voluntary help given in this county. Such organizations as the W.R.V.S., B.R.C.S., and Old Peoples' Welfare Committees provided over a quarter of a million meals to elderly people in their own homes and served 112,000 meals at luncheon clubs. The Hertfordshire Old Peoples' Welfare Council and its associated welfare committees continued their invaluable work with the formation of still more old peoples' clubs—there are now 118 in the county—in arranging social visits and outings and by organizing exhibitions. In addition the Old Peoples' Welfare Council held information courses for the officers of the clubs and committees.

The Health and Welfare Committee appreciate the fact that there is a limit to the amount of time and effort which can be expected of these voluntary organizations and have agreed in principle that the county council should give greater financial support to their activities.

A further service designed to enable the elderly to remain in the community is that of the warden-assisted housing accommodation provided by district councils and housing associations and it is encouraging to note that the number of units within the county at the end of 1970 was 2,338, with plans already in hand for new schemes in 1971.

Residential Accommodation.

Building Programme.

One new Home was brought into use during the year, viz. Gadebury, Hemel Hempstead (60 beds), bringing the total number of beds in County Homes to 1,471.

Unfortunately this brought the building programme to a standstill as it had not been possible to obtain loan sanction for any immediate projects. It is, however, pleasing to report that the programme subsequently received from the Department of Health and Social Security allowed for a commencement to be made during the next three years on Homes at St. Albans (2), Potters Bar, Hatfield, Knebworth, and Oxhey, although the approval for the 2 St. Albans Homes is dependent on the closure of the ex-Public Assistance Institution at Waverley Lodge, St. Albans (112 beds).

In the meantime, the waiting list continued to expand and at the end of the year stood at 1,192 (878 women and 314 men).

Admissions and Discharges.

During the year there were a total of 438 new permanent admissions to Homes and 554 discharges, of whom 145 were subsequently re-admitted from hospital. The following comparative statement summarizes the sources from which people were admitted and the reasons for their discharge over the last three years :—

TABLE 31.

	1970.	*1969.*	*1968.*
Admissions.			
From own home (living alone)	119	103	124
From own home (living with relatives)	120	93	132
From lodgings	28	28	19
From hospital (initial admission)	136	125	142
From mental hospital (initial admission)	7	8	15
From another County by arrangement	5	5	5
From Private Old People's Home	11	10	5
No fixed abode	12	12	5
New permanent admissions	438	384	447
Re-admission after period in hospital	145	148	178
Totals	583	532	625
Discharges.			
To hospital	329	333	356
To mental hospitals	36	33	33
To relatives or other private accommodation	37	30	38
Deaths	152	133	149
Totals	554	529	576

The age groups of new permanent admissions were as follows :—

	50–64.	*65–74.*	*75–84.*	*85 and over.*	*Total.*
Men	20	44	64	39	167
Women	7	40	131	97	271
					438

All staff and residents who so desired were again immunized against influenza, and very few cases were reported.

Short Stay Care.

Short stay care has continued, mainly to afford a break for relatives caring for their elders or to enable those relatives to go on holiday, and 302 persons were admitted, generally for a period of two weeks. This valuable and worthwhile service was becoming increasingly difficult to maintain in view of the pressure of urgent applications for permanent admission and the delay in building further Homes.

Training Courses for Senior Staff.

During the year, 3 officers were seconded to the new 1-year courses for senior staff of Residential Homes at Ipswich Civic College and Liverpool College of Commerce.

In addition, an in-service training course for senior staff was also commenced at the St. Albans College of Further Education under the auspices of the Council for Training in Social Work. This was on the basis of day release for 1 day per week for the College year ; a part-time tutor being provided by arrangement with the Education Committee.

Voluntary Homes.

Use continued to be made of accommodation in approved voluntary Homes and at 31st December, 1970, there were 330 such residents for whose maintenance the county council was responsible.

In the main these residents were elderly, but the following were accommodated in "specialist" Homes :—

TABLE 32.

Type of Home.	*No. of Residents.*
Homes for the blind . . .	34
Homes for the deaf . . .	6
Homes for the epileptic . .	30
Homes for the disabled . .	55
	125

REGISTRATION OF HOMES FOR DISABLED AND OLD PERSONS.

During the year 3 further Homes were registered with the county council, 2 closed down and 2 others ceased to be registrable on becoming eligible for grant-aid under the scheme for the provision of warden-serviced housing accommodation in accordance with Section 119 of the Housing Act, 1958. These changes, combined with minor variations in the number of places in existing registered Homes resulted in the overall number of places being increased from 839 to 854.

These Homes form an important and valuable supplement to the county council's own Homes for the Aged and in a number of instances afford specialized accommodation for persons with particular needs, e.g. severe physical handicap, blindness, and for individuals of various religious denominations.

TABLE 33.

No. of Registered Homes.	*No. of places registered.*			
	Men only.	*Women only.*	*Both sexes.*	*Totals.*
Private.				
Elderly.				
2	—	18	—	
13	—	—	232	
15				250
Voluntary.				
Elderly.				
1	29	—	—	
5	—	120	—	
12	—	—	361	
18				510
Disabled.				
1	—	15 (blind)	—	
3	—	—	79 (30 blind)	
4				94
Totals : 37 Homes.				854 beds.

In addition there is 1 Home in the county which provides accommodation for 30 blind persons of either sex which is not registrable as it is managed by a body incorporated by Royal Charter.

HOME HELP SERVICE.

The home help service continued to be provided under Section 29 of the National Health Service Act, 1946, but with the passing of the Social Services Act, 1970, provision of the service became the responsibility of the new Social Services Committee from 1st April, 1971.

1970 was a year of consolidation for the home help service in the county. The development of the newly formed posts of divisional home help organizers was watched with interest. Guidance and support was given to the officers concerned by both divisional medical officers and headquarters staff. The posts of area organizers assumed a new dimension with the employment of assistant organizers appointed to a structured career rather than, as previously, to a part-time post with an indeterminate future.

Tables of statistics relating to the service are given below :—

TABLE 34.—WEEKLY HOURS AND STAFFING.

Cases helped during year	Cases current at :		Average weekly hours, Dec., 1969	Equivalent No. of full-time Home Helps 1969	Average weekly hours, Dec., 1970	Equivalent No. of full-time Home Helps 1970	No. of Organizers and Clerks					
							Dec., 1969			Dec., 1970		
	1.1.70	31.12.70					Full-time	Part-time	Equivalent full-time	Full-time	Part-time	Equivalent full-time
6,846	4,244	4,468	15,844	367·1	16,365	409·1	23	17	32·34	23	21	34·18

TABLE 35.—CASES HELPED DURING 1970.

	Maternity and nursing mothers	Mental illness	Tuberculosis	Chronic sick	Blind	Acute illness	Accidents	Miscellaneous	Total
Persons of pensionable age	—	41	16	4,871	219	92	42	5	5,926
Other cases .	559	43	18	453	24	394	21	48	1,550
Totals . .	559	84	34	5,324	243	486	63	53	6,846

Good Neighbour Cases — 142. Night Sitter Cases — 32. Family Help Cases — 3.

TABLE 36.—ALLOCATION OF HELP.

Category.	*Percentage of cases helped.*		*Percentage of help given.*	
	1970.	*1969*	*1970.*	*1969.*
Maternity . .	8·2	8·9	1·0	1·9
Mental illness .	1·3	1·6	1·7	1·1
Tuberculosis . .	0·5	0·5	0·7	0·7
Chronic sick . .	77·8	76·8	88·0	88·2
Blind . . .	3·5	3·4	4·7	4·7
Acute illness . .	7·1	7·0	2·8	2·2
Accidents . .	0·9	1·1	0·4	0·5
Miscellaneous .	0·7	0·7	0·7	0·7

Percentage of cases of pensionable age — 77·8 (1969 — 75·4).

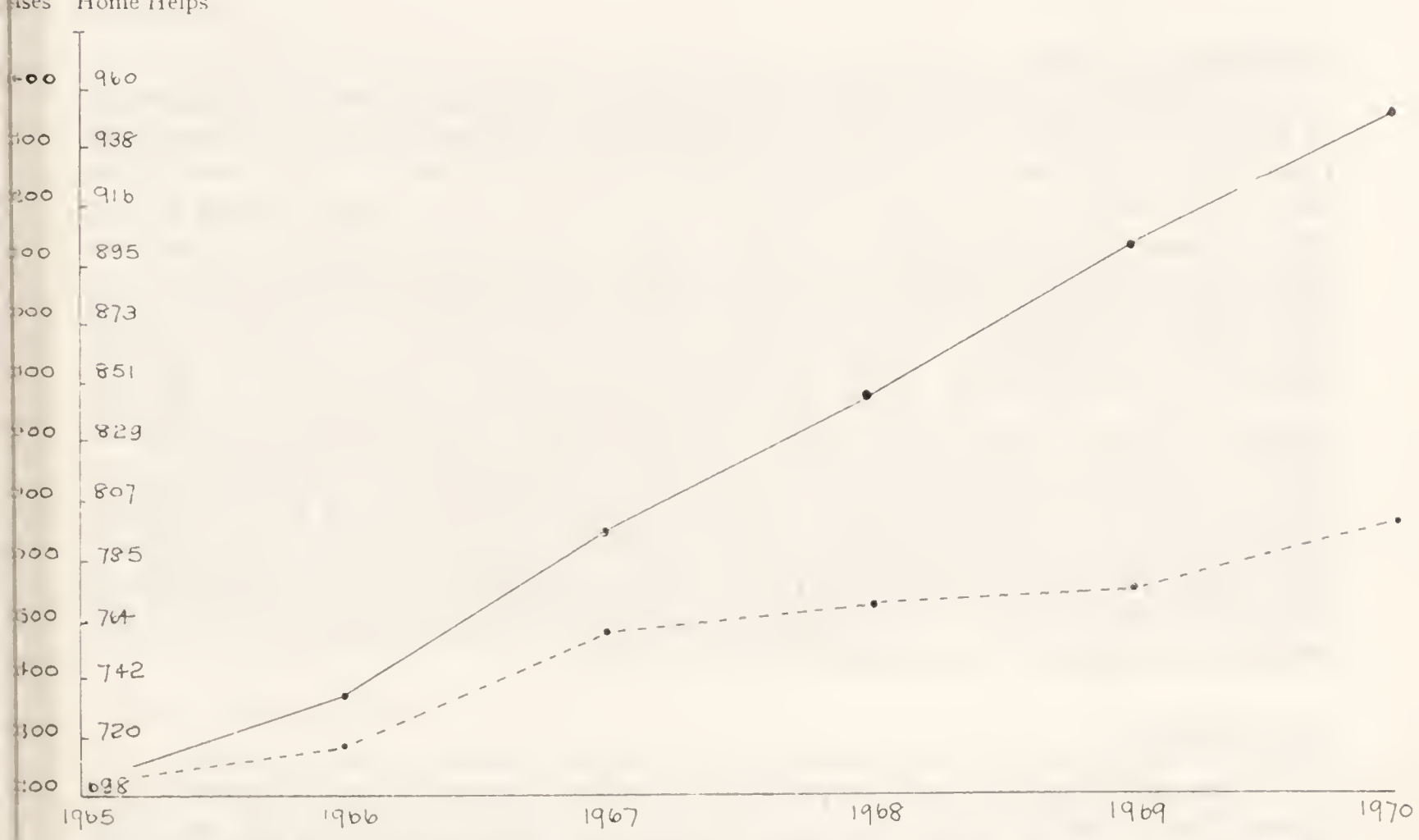
TABLE 37.—MATERNITY AND CHRONIC SICK CASES 1965 TO 1970 SHOWING PERCENTAGE OF THE TOTAL CASES HELPED.

	Maternity cases.	*Chronic sick cases.*	*Combined totals.*
1965 . .	1,131 (18·8%)	4,007 (66·5%)	5,138 (85·3%)
1966 . .	955 (16·0%)	4,104 (68·9%)	5,059 (84·9%)
1967 . .	850 (13·8%)	4,386 (71·1%)	5,236 (84·9%)
1968 . .	674 (10·5%)	4,732 (74·3%)	5,406 (84·8%)
1969 . .	573 (8·9%)	4,949 (76·8%)	5,522 (85·7%)
1970 . .	559 (8·2%)	5,324 (77·8%)	5,883 (86·0%)

Home Helps.

The position regarding recruitment of home helps continued to be a matter for concern, the national review of the rates of pay of home helps proved to be a lengthy one. The subsequent improvement in pay was publicized throughout the county, through the services of the press officer, and was followed up by local advertising, where the need was indicated. The immediate responce was encouraging, but it remains to be seen whether this will prove more than a short-term boost to recruitment. (At the time of writing this report the responce has been an increase of 80 part-time home helps.)

As a matter of interest, details are given below which show the trend in the ratio of home helps to cases since 1965 :—



The table illustrates the increasing shortage of home helps in comparison with the increase in new cases. In 1965, the situation was considered serious enough to warrant a recruitment campaign in one division, which was followed by campaigns in two other divisions during 1966. The position has gradually worsened and in 1970 the case load per home help was 19 per cent higher than in 1965.

Not only is it true that the number of cases has increased more rapidly than the number of home helps available to provide a service, but the proportion of maternity and acute illness cases, which make less demand on the time of the home help service than the chronic sick, has decreased. The average help given

to a maternity case in a year is 28 hours while the average given to a chronic sick case is 136½ hours, i.e., nearly five times as much.

Extracts from Annual Reports prior to 1965 read :—1961 Staffing difficult ; 1962 Service still understaffed ; 1963 Staffing a difficult problem ; 1964 Recruitment does not keep pace with growth.

Long-Service Badges.

The presentation of long-service badges to home helps was commenced in 1955, awards being made to those with 5 and 10 years' service. The ceremony is held in the council chamber, and afternoon tea is provided. Home help organizers accompany their staff and, where necessary, transport is arranged.

The badge presentation has become a tradition in the home help service of this County, and in 1967 requests were received to extend the awards to those with 15 and 20 years' service. Approval was given, and in 1968 new badges were prepared for these longer-serving home helps. With the extension of these awards, the presentation has increased in popularity, the longer-serving home helps being given additional opportunities of coming to Hertford to meet colleagues from other divisions, and they derived satisfaction from these contacts.

85 home helps were awarded badges this year, and 50 came to County Hall to receive them from Lady Grenfell. County Councillor, Mr. H. L. Morbey, Chairman of the Health and Welfare Committee presided, and several Members were present.

The total number of badges presented since 1955 is 940.

Attachment Scheme.

The attachment of particular home helps to elderly people living in groups of sheltered housing was tried as an experiment during the year. It was felt that there might be a two-fold advantage in this method in that older home helps, with long service, might find this a less strenuous task, and the old people gain a closer relationship with the home help, who would be able to move more easily from person to person within the group, and be more readily available for any sudden emergency amongst them. In the event, the system worked smoothly, the tendency, however, being that far greater pressure was experienced by the home help, many demands and requests being made by the old people which she was quite unable to meet within her programme of duties. This indicated that the selection of a home help for a situation of this kind might need to go beyond the long-service help. Attachment in this way would seem to require a woman with particular skill in handling a situation where the satisfactory performance of her duties depends on her capacity to deal, in a diplomatic way, with innumerable interruptions requesting extra services which she has neither the time nor the authority to carry out.

International.

Hertfordshire was well represented at the International Conference of Home Helps which was arranged by the National Council of Home Help Services and held at Froebel College, London, in April. Each division was represented by one home help, sponsored by the Authority to attend the full conference lasting 4 days. Additionally, 17 home helps attended on the last day when foreign delegates gave summaries of their services. The County Organizer served on the International Conference Committee as the Accommodation Officer. Delegates from 15 countries attended the conference which was opened by Dr. John Dunwoody, Parliamentary Under-Secretary of State. This was the second international conference to be held, and home helps who attended were very enthusiastic about the project, and were able to report back to colleagues in their own divisions.

Training.

Eleven organizers attended the Weekend School of the Institute of Home Help Organizers held at Malvern in September.

During the year, arrangements were made for one of the new assistant organizers to commence the course of study for the Certificate in Home Help Organization.

The training of home helps throughout the county was continued by local discussion group teaching in the first instance, followed by divisional training courses held, where possible, in Colleges of Further Education. Thus, Area Organizers prepared their home helps in their local groups for participation in the divisional course where they met colleagues from other parts of their division. Divisional Organizers arranged the divisional course. This method of training, with amendments and improvements, has continued steadily since 1965, and time has shown that home helps derive much interest and satisfaction from this scheme of training.

The talks given at the training courses are by college lecturers, doctors, nurses, health visitors, public health inspectors, social workers, health education officers, fire brigade personnel, voluntary personnel, etc., who take a lively interest in making the sessions enjoyable, as well as instructive.

The support of the colleges, particularly through the Home Economics Department, has been invaluable, and where accommodation at the colleges has been provided for the duration of the course, this was of a high standard and contributed much to the comfort of the home helps, and the efficiency and effectiveness of the training courses.

Good Neighbour Service.

This service has proved of inestimable value to many people, particularly the severely handicapped, the aged sick, and in some cases, the acute sick. 142 cases were helped compared with 166 in 1969.

Night Sitter Service.

The improvements made to this service in 1969 proved their worth this year, 32 cases being assisted (compared with a handful of cases over the past several years). This represented approximately 250 attendances, and service was given in only 5 of the 18 home help service areas. An average of 3 to 4 cases received the service each week during the year.

Although divisional home help organizers have set up registers of night sitters, difficulty was sometimes experienced in securing the services of a night sitter at short notice. It has been found that, if need for their services does not arise within reasonable periods of time, night sitters no longer continued to be available. It was thought that consideration might need to be given to the payment of a retaining fee in certain circumstances.

Family Help Service.

This new service, which was set up specifically to help families with difficulties, was used in 1 division, 3 family helpers being employed to assist families with special needs. While, in some cases, help to families continued to be given through the home help service, the use of the new-type family helper ensured continuity of service to the families concerned. The family help service, it is expected, will be put to considerable use in the new social services department.

CHIROPODY SERVICE.

The service has grown at a faster rate than in recent years, with the number of treatments increasing by 9·6 per cent compared with 1969. The figures for previous years were 7·2 per cent for 1968–69 and 7·4 per cent for 1967–68. The

number of patients treated during the year was 10,596, an increase of 14·34 per cent on the number for 1969.

The treatment figures for the last three years are given below :—

TABLE 38.—TREATMENTS.

	1970.	*1969.*	*1968.*
Private Chiropodists.			
At sessions	8,643 (16·1%)	8,414 (16·8%)	8,536 (18·3%)
In surgeries	26,558 (49·2%)	25,354 (50·7%)	24,004 (51·4%)
At home	13,785 (34·7%)	16,274 (32·5%)	14,157 (30·3%)
	53,986	50,042	46,697
County Chiropodists.			
At sessions	2,613 (71·7%)	1,728 (67·9%)	1,503 (64·2%)
At home	1,040 (28·3%)	817 (32·1%)	839 (35·8%)
	3,653	2,545	2,342
Combined Totals.			
At sessions	11,256 (19·5%)	10,142 (19·3%)	10,039 (20·5%)
In surgeries	26,558 (46·1%)	25,354 (48·2%)	24,004 (48·9%)
At home	19,825 (34·4%)	17,091 (32·5%)	14,996 (30·6%)
	57,639	52,587	49,039

The proportion of home treatments has again increased, with more than 34 per cent of treatments being given to housebound patients. The service was received almost entirely by the elderly only.

There was still a general shortage of chiropodists in the county, with North Herts finding it most difficult to meet demand.

PART III—MANAGEMENT SERVICES.

TABLE 39.—STAFF IN EMPLOYMENT AT 31ST DECEMBER, 1970.

(*Equivalent Whole-Time*).

Central Administration.		
Medical and other professional	7·0	
Administrative and clerical	85·6	
	——	92.6
Divisional Administration.		
Medical and other professional	24·0	
Administrative and clerical	68·5	
	——	92·5
Health and School Health Services.		
Day nurseries—		
Nursery staff	71·0	
Domestics	17·3	
Departmental Medical Officers	24·0	
Dentists and dental auxiliaries	21·7	
Dental surgery assistants	35·5	
Domiciliary nursing service	430·0	
Health Education Officers and clerks	7·5	
Child Guidance—psychiatric social workers, social workers, psychotherapists, and clerks	35·5	
Speech therapists	16·5	
Orthoptists	3·2	
Audiometricians	4·0	
Ambulance Service	282·5	
Miscellaneous professional and other officers	6·0	
Clerical	22·5	
Caretakers, cleaners, and drivers	33·2	
	——	1,009·9
Social Welfare Services.		
Chiropodist	2·0	
Home Help Organizers and clerks	32·7	
Home Helps	410·8	
Mental Health—Training Centres—		
supervisory	119·6	
other	25·2	
Mental health—Residential Accommodation—		
supervisory	23·8	
other	14·3	
Residential Accommodation for the Elderly and the Infirm—		
supervisory and nursing	115·0	
other	495·7	
Social Work Units—		
Social workers	95·7	
Clerical and miscellaneous	26·2	
	——	1,361·0
Chaplains and Medical Officers (Residential Homes and Hostels	28 P.T.	—
Total		2,556·0

CAPITAL PROGRAMME AND EXPANSION OF THE SERVICE.

The new Health Centre at Buntingford, incorporating facilities for the local general practitioners, was opened by the Chairman of the Health and Welfare Committee on 21st October, 1970. Clinic facilities for this small town had been provided for many years at rented premises at Bridgefoot House and the new Centre is a considerable improvement.

Negotiations and preparatory work continues for Health Centres in Royston, St. Nicholas, Stevenage, and Old Stevenage and others. Whilst real progress was made towards new buildings at Royston and St. Nicholas, it became necessary to rent temporary premises for the clinic at Old Stevenage. Negotiations are now in hand for centres at Harpenden, Much Hadham, Puckeridge, Waltham Cross, and Ware, with preliminary investigation on many other schemes.

During 1970, local authorities had expressed growing concern at the services and conditions, particularly related to rent, under which facilities for the local Executive Councils were provided in local authority Health Centres and improved terms have now been announced.

The new Day Nursery of 50 places at Oxhley Way, Oxhey, came into use in August and it was finally possible to discontinue use of the unsatisfactory wartime building at Bushey. The Committee has for many years planned to build new Day Nurseries at St. Albans (to replace Fleetville) and at Hemel Hempstead and Stevenage, but has been prevented by difficulty in obtaining loan sanction and, in the case of St. Albans, obtaining a suitable site. It is therefore pleasing to record that it now appears it will be possible to build this new Nursery on the site at Sandfield School and that the Social Services Committee has had capital monies allocated for all three Day Nurseries.

There are also indications that more capital money will be devoted to Mental Health projects. The Health and Welfare Committee's programme to build 20 hostels in 10 years from 1963 had been frustrated by lack of funds but the growing national concern about Mental Health Services has led to much greater emphasis being placed on the residential projects and it would appear that large sums of money will be set aside to provide new hostels by the 1980s. In Hertfordshire substantial progress was made in 1970 in the erection of the hostel for the Mentally Ill at Watford and in the conversion of Rowneybury, Sawbridgeworth for mentally handicapped children. The conversion of Roe Hill House as a rehabilitation hostel for former drug users was completed. A great deal of time has been devoted to negotiations about sites for new hostels. It is encouraging to note that, whilst public anxiety continues to be excited about specific proposals there is more willingness to understand the problem of providing hostels in the proper locations and proposals are receiving a more sympathetic hearing.

In the previous annual report attention was drawn to the very poor capital allocation afforded by the government for old persons homes, but the hope was offered that the immediate future ought to show an improvement. It is therefore pleasant to record that current programmes offer two schemes per annum for the next three years and much preparatory work was carried out for the projects at Wroxham Gardens, Potters Bar ; Beechfield, Watford ; King Harry Lane and Waverley Lodge, St. Albans and Townfield, Hatfield, all of which are expected to be in course of erection by the autumn of 1971.

PART IV—SCHOOL HEALTH SERVICE.

There was little change in the general administration of the school health service during 1970. The scheme of selective medical examination which started over the whole county the year previously continued in operation, with the more comprehensive examination of the entrants into infants school its basic measure. Children passed as fit in health then may not be seen again as a routine action, although the head teachers with the parents agreement or the parents themselves can request a child being seen at any time. Those who are found to have a defect which would not appear to require treatment at that time are observed regularly during succeeding years until either treatment is advised or their health is considered satisfactory.

One important part of this new scheme is a closer liaison now between the medical and health visiting staff and the teachers in the schools so that the problems of any pupil can be readily discussed and action, if necessary, taken. The value of this multi-professional approach to the needs of the school child need hardly be emphasized, and must be remembered in any future re-arrangement of the school health service.

The tables at the end of this report give the details of the work done by the medical and nursing staffs and of their findings at the examination. There was little marked change from previous years with more children in schools and thus more medical inspections. There was a slight increase in the ear, nose, throat and skin conditions and also in those psychological in origin. An increasingly high percentage of children in whom defects were noted were already having treatment, a good indication of the use being made of the national health Services.

There was an unfortunate drop in the number of secondary school entrants who received B.C.G. vaccination owing to a shortage of medical officers, but it is intended that the children who were missed will receive the vaccine during 1971.

TABLE 40.—MEDICAL INSPECTIONS.

	1970.	*1969.*
Number of pupils on registers of maintained Primary, Secondary, and Special schools.	172,556	166,174
Number of periodic medical inspections	19,421	17,013
Number of special inspections	4,672	2,799
Number of re-inspections	14,828	18,637

TABLE 41.—DEFECTS FOUND BY MEDICAL INSPECTIONS.

Defect (1)	Number of Defects							
	Already under treatment (2)		Recommended treatment (3)		Total (4)		Under observation (5)	
	1969	*1970*	1969	*1970*	1969	*1970*	1969	*1970*
Skin	175	*239*	75	*99*	250	*338*	391	*498*
Eyes :								
(*a*) Vision	398	*421*	296	*241*	694	*662*	501	*452*
(*b*) Squint	188	*246*	76	*93*	264	*339*	172	*173*
(*c*) Other	23	*17*	19	*16*	42	*33*	78	*87*
Ears :								
(*a*) Hearing	80	*96*	150	*168*	230	*264*	660	*747*
(*b*) Otitis Media	67	*62*	43	*48*	110	*110*	526	*739*
(*c*) Other	20	*7*	6	*8*	26	*15*	193	*84*
Nose or Throat	137	*159*	66	*89*	203	*248*	1,321	*1,562*
Speech	104	*108*	121	*120*	225	*228*	476	*640*
Lymphatic Glands	14	*13*	13	*8*	27	*21*	483	*616*
Heart	35	*32*	9	*13*	44	*45*	289	*382*
Lungs	84	*113*	20	*23*	104	*136*	601	*707*
Developmental :								
(*a*) Hernia	14	*11*	17	*19*	31	*30*	72	*66*
(*b*) Other	22	*26*	35	*50*	57	*76*	349	*419*
Orthopaedic :								
(*a*) Posture	12	*5*	17	*18*	29	*23*	126	*101*
(*b*) Feet	42	*55*	36	*48*	78	*103*	358	*450*
(*c*) Other	66	*40*	37	*25*	103	*65*	330	*354*
Nervous System :								
(*a*) Epilepsy	38	*40*	3	*3*	41	*43*	61	*68*
(*b*) Other	23	*20*	6	*4*	29	*24*	149	*195*
Psychological :								
(*a*) Development	12	*25*	44	*49*	56	*74*	556	*619*
(*b*) Stability	28	*50*	64	*57*	92	*107*	693	*948*
Abdomen	23	*32*	13	*22*	36	*54*	163	*190*
Other	41	*41*	44	*25*	85	*66*	210	*254*
Total no. of defects found	1,646	*1,858*	1,210	*1,246*	2,856	*3,104*	8,758	*10,351*
Percentage of total defects	57·63	*59·86*	42·37	*40·14*				

THE COUNTY DENTAL SERVICE, 1970.

Staff.

The year commenced with a staff of 19 salaried officers and 20 sessional officers whose total whole time equivalent was 25·5 dental officers. There were also 7 full-time dental auxiliaries in post. In contrast to the two previous years staffing movements to and from the service were more marked with 1 resignation and 1 appointment at divisional dental officer grade, 3 resignations from salaried

dental officer posts and 3 resignations from and 11 appointments to sessional dental officer posts. Amongst dental auxiliaries there were 4 resignations and 3 appointments leaving a loss of 1 full-time post. It was not possible to replace the salaried dental officer posts by similar appointments but the position was partially restored by the sessional appointments. The end of the year staffing figure for dental officers was 16 salaried posts and 28 sessional posts, the total whole-time equivalent of which was 24·6 officers which represents a loss of nearly 1 full-time post compared with the position at the commencement of the year.

Clinics.

A new replacement dental clinic was opened during the year at Buntingford. The clinic is part of the new Health Centre in which surgery accommodation is provided for three general medical practitioners and for the usual local health authority services. In the planning stage of this Centre a dental practitioner expressed interest in the possibility of sharing the dental suite on a part-time basis in order to provide general dental services for the town. These early negotiations, however, did not proceed to fruition and the first local authority health centre in which the general dental service is represented has yet to be built in this county.

The closure of the old dental clinic in Buntingford marked the end of a clinic replacement programme of sub-standard premises which had been continuing since 1958, where facilities and working conditions were far from satisfactory. The total number of clinics in use in the county remained as in the previous year at 36. Of these clinics 9 have 2 surgeries, 1 has 3 surgeries and the remaining 26 are single-surgery centres producing a total of 47 surgeries, all of which were in use. Whilst staffing remained a problem in a number of areas, there were parts of the county where the service was limited also by the shortage of clinic premises, the most obvious examples of which were at Stevenage and Ware.

Equipment.

The process of replacing older items and the modernization of larger items of equipment continued with the installation of 7 thermostatically controlled 3-in-1 syringes and 4 air-bearing high speed drills. In addition it was necessary to replace 2 obsolete general anaesthetic machines.

Dental Auxiliaries.

The revised Anciliary Dental Workers Regulations which were laid before Parliament in March, 1968, came into operation on 1st September, 1969. These Regulations made provision for the permanent establishment of dental auxiliaries in local authority health services and also modified the conditions under which they were permitted to work in clinics. Previous to September, 1969, it was essential for a dental officer to be on the premises at all times when clinical work was undertaken by a dental auxiliary. This restriction meant that dental auxiliaries were obliged, as a result of the foreseen or unforeseen absence of a dental officer, to spend sessional time on work other than chairside treatment. With a staff of 6 or 7 dental auxiliaries, this resulted in the loss of an appreciable number of clinical sessions over a full year. Under the new regulations it is no longer essential for a dental auxiliary to work under the continuous personal supervision of a dental officer and the extent to which this is considered necessary is left to the directing dentist to decide in the light of his personal assessment of the skill, experience, and ability of each dental auxiliary. This modification to the regulations has resulted in a substantial increase in the number of clinical sessions worked by auxiliaries this year.

Postgraduate Courses.

Postgraduate courses were attended during the year by 6 officers of the full-time staff. 1 divisional dental officer attended an orthodontic course in London on 10 Saturday mornings during the early part of the year. 2 divisional

dental officers attended a short residential course at Oxford on anaesthesia and Planning in Children's Dentistry and 1 dental officer attended a 5-day course in London on Children's Dentistry. The divisional dental officer for the South West division, Mr. R. J. Smee, attended an extended course in Dental Public Health and is to be congratulated on obtaining his diploma in this subject following the final examination in July. Mr. J. F. Crawford, one of our full-time orthodontists, attended a part time refresher course at the Royal Dental Hospital during the latter part of 1970 and the earlier part of 1971. He is to be congratulated on obtaining his Diploma in Orthodontics following the examination in March, 1971.

Treatment—Pre-school Children and Mothers.

The amount of time allocated to pre-school children and expectant and nursing mothers is lower by 91 sessions this year and this has resulted in a reduction of 8 per cent in the amount of conservative work carried out. Although the overall number of sessions covering the combined work of dental officers and dental auxiliaries was reduced, the amount of time given to the service by dental auxiliaries increased slightly. The proportion of fillings done for children under 5 by dental auxiliaries increased from 43 per cent of the total in 1969 to 58 per cent this year.

Treatment—Schoolchildren.

Compared with the previous year the total number of treatment sessions carried out by dental officers showed a reduction of 154 sessions. On the other hand the number of treatment sessions undertaken by dental auxiliaries was higher by 872 sessions thus producing a net increase of 780 operating sessions. This increase resulted in 1,585 more patients being treated and 6,179 more attendances being made for treatment. The number of treatments carried out showed increases of 2,563 fillings in permanent teeth, 2,035 fillings in deciduous teeth, and corresponding increases in extractions of 322 permanent teeth and 1,142 deciduous teeth. The total number of courses of treatment commenced increased by 1,898 whilst the number of completed treatments improved by 1,410. Of the 96,873 children who were inspected this year 40,331 were offered treatment and 25,901 were actually treated, thus producing an acceptance rate for treatment of 64 per cent. This is a higher figure than the previous year and indicates an increasing demand upon our service.

Conclusion.

Dental officer staffing problems have intruded to a greater extent this year and the early loss of three full-time dental officers produced difficulties of treatment coverage in three of the county divisions which were only resolved by the redeployment and willing co-operation of the staff in the areas concerned. As in previous years I express my appreciation of the efforts made by the staff and look forward to a service which will be able to offer inspection and treatment to an increased proportion of the schoolchildren in Hertfordshire in the future.

Table 42.—Dental Inspection and Treatment.

School Dental Service.

Number of pupils on school registers (1.1.71)		171,464
(1) *Inspections.*		
(*a*) First inspection—school	80,404	110,136
(*b*) First inspection—clinic	16,469	
(*c*) Re-inspection—school/clinic	13,263	
Number of pupils requiring treatment (*a*) and (*b*)	49,089	56,206
Number of pupils requiring treatment (*c*)	7,117	
Number of pupils offered treatment (*a*) and (*b*)		40,331

(2) *Visits* (for treatment only).

	Ages 5–9.	*Ages 10–14.*	*Ages 15–over.*	*Total.*
First visit—calendar year	13,489	10,284	2,128	25,901
Subsequent visits	25,928	23,719	4,876	54,523
Totals	39,417	34,003	7,004	80,424

(3) *Courses of Treatment.*

Additional courses commenced	3,393	1,831	261	5,485
Total courses commenced	16,882	12,115	2,389	31,386
Courses completed				24,237

(4) *Treatment.*

Fillings permanent teeth	11,804	21,778	5,652	39,324
Fillings deciduous teeth	22,703	2,413	—	25,116
Permanent teeth filled	9,600	18,501	4,956	33,057
Deciduous teeth filled	20,392	2,173	—	22,565
Permanent teeth extracted	482	2,750	658	3,890
Deciduous teeth extracted	11,394	3,363	—	14,757
General Anaesthetics	4,496	1,875	227	6,598
Emergencies	2,411	1,148	239	3,798
Number of pupils X-rayed				3,014
Prophylaxis				6,626
Teeth otherwise conserved				5,088
Teeth root filled				125
Inlays				2
Crowns				116

(5) *Orthodontics.*

New cases commenced during year	472
Cases completed	478
Cases discontinued	77
Number of removable appliances fitted	894
Number of fixed appliances fitted	141
Number of pupils referred to hospital consultants	23

(6) *Dentures.*

Number of pupils fitted for the first time.				
(*a*) With full denture	—	—	—	—
(*b*) With other dentures	12	48	9	69
(*c*) Number of dentures supplied	12	49	9	70

(7) *Anaesthetics.*

Administered by dental officers	9

(8) *Sessions.*

	Admin.	*Insp.*	*Treatment.*	*Health Ed.*	*Total.*
Dental officers	595	648	9,472	2	10,717
Dental auxiliaries	—	—	2,411	87	2,498
Dental hygienists	—	—	—	—	—

Dental Services for Expectant and Nursing Mothers and Children Under Five Years.

Attendances and Treatment.

	Children 0–4 (incl.)	*Expectant and Nursing Mothers.*
Number of Visits for Treatment During Year.		
First visit	2,165	162
Subsequent visits	3,858	327
Total visits	6,023	489
Number of additional courses of treatment other than the first course commenced during year	422	12
Treatment provided during the year—number of fillings	5,029	363
Teeth filled	4,456	325
Teeth extracted	1,179	114
General anaesthetics given	575	13
Emergency visits by patients	315	18
Patients X-rayed	45	28
Patients treated by scaling and/or removal of stains from the teeth (Prophylaxis)	710	121
Teeth otherwise conserved	643	—
Teeth root filled	—	7
Inlays	—	2
Crowns	—	—
Number of courses of treatment completed during the year	1,971	112

Prosthetics.

Patients supplied with F.U. or F.L. (first time)	4
Patients supplied with other dentures	16
Number of dentures supplied	23

	Children 0–4 (incl.)	*Expectant and Nursing Mothers.*
Inspections.		
Number of patients given first inspections during year	4,064	216
Number of patients who required treatment	2,199	185
Number of patients who were offered treatment	2,171	184

Sessions.

Number of dental officer sessions (i.e. equivalent complete half days) devoted to maternity and child welfare patients.	For treatment	1,248
	For health education	8

OPHTHALMIC AND ORTHOPTIC SERVICE.

Children are routinely examined to check their visual acuity, and those with defects are offered appointments at the various ophthalmic clinics. Parents can, however, as an alternative to the clinics, take their children to ophthalmic opticians. Glasses, if prescribed, are supplied free of charge by opticians on the list of the Hertfordshire Executive Council.

The ophthalmic clinics are staffed by consultant ophthalmologists under an arrangement with the Regional Hospital Boards. Unfortunately, during 1970, Dr. Gardener, who had for so many years attended the ophthalmic clinics in both Watford and Hemel Hempstead, resigned his appointments because of ill-health. He will be greatly missed in these clinics which he had helped so much to build up to a high level of excellence.

Some changes also took place among the other ophthalmologists, and it will be seen that the number of sessions decreased quite considerably last year compared with the year previous. Although the number of refractions was also fewer, the number of pupils for whom spectacles were prescribed remained fairly constant.

The use of vision screeners in greater numbers throughout the county for the routine testing of the vision of children of 7 years upwards did help to overcome the difficulties which had been met in previous years in trying to test the eye-sight of children with the varying distances available in schools for this purpose and the varying degrees of illumination.

TABLE 43.—OPHTHALMIC CLINICS, 1970.

Centres	No. of Sessions	Attendances		No. of Refractions	No. of pupils for whom spectacles were prescribed
		New	Rx.s		
North Herts.					
Hitchin	42	106	245	94	38
Stevenage	45	107	287	131	64
East Herts.					
Hertford	76	106	482	561	179
Bishop's Stortford	29	258	93	339	127
Buntingford	4	25	53	—	12
Cheshunt	39	120	345	417	149
Mid-Herts.					
Hatfield	22	46	265	186	104
Welwyn Garden City	44	121	604	344	235
St. Albans.					
St. Albans	68	288	584	860	300
Harpenden	23	73	202	261	114
Boreham Wood	42	65	489	204	109
South-West Herts.					
Watford	139	542	690	1,130	296
Rickmansworth	18	61	97	158	53
Dacorum.					
Berkhamsted	2	30	12	40	5
Hemel Hempstead	56	250	357	599	253
Totals	649	2,198	4,805	5,324	2,038

It was possible during the year to fill some of the vacancies in the orthoptic service, and this resulted in more sessions in the clinics and more children seen. Facilitities for operations for sqaint were not available in all the hospitals in the county, and children requiring this treatment in the west of Hertfordshire had to be referred to the Watford Hospital. As more pre-school children were being referred to the clinics for the treatment of their squints, it was hoped that the lack of facilities could be overcome in the future.

TABLE 44.—ORTHOPTIC CLINICS, 1970.

Clinic	Sessions	Attendances	No. of Children as at 31.12.70		Waiting List of new cases as at 31.12.70
			Under treatment	Under observation	
Stevenage . .	65	300	78	96	5
Hitchin . .	189	1,141	28	318	—
Cheshunt . .	28	206	13	87	3
Ware . . .	28	117	4	47	—
Hatfield . .	55	490	26	126	—
Welwyn Garden City	136	1,055	60	260	—
St. Albans . .	256	1,388	7	469	—
Watford/Oxhey .	494	3,111	38	55	13
Hemel Hempstead .	174	1,119	63	79	24
Totals . .	1,425	8,927	317	1,536	45

AUDIOLOGY SERVICE.

The importance of knowing whether a child has a hearing deficiency cannot be gainsaid, nor that this should become known as soon as possible. Not only can hearing aids be made available to babies, but also mothers can be shown procedures which they should follow in the home and elsewhere to lessen the effect of a defect of hearing and, when a hearing aid is recommended, to help the child to accept it.

The testing by health visitors of the hearing of babies at the age of 6–9 months has become an essential part of their duties. Young children found to have or suspected of having a hearing defect are referred for investigation to the consultant otologist, Dr. Bickerton, who is in charge of the county's audiology service. By these means, all children having a congenital hearing defect should be found early, but another screening, this time by audiometricians with audiometers, is carried out on all entrants to infants school. Diseases of the ear, nose, and throat during school life can affect a child's hearing either permanently or temporarily, and it is hoped that it will not be too long before enough audiometricians can be found to carry out another screening test on children before they leave their primary school.

Facilities in the county for children handicapped in this way continue to increase, and the following reports from Dr. Bickerton and Mr. Grossman, the county council advisor on audiology, mention some of the advances.

M. V. Bickerton, County Consultant Audiologist reports :—

The audiometricians again, owing to shortage of staff, have had difficulty in covering the North East division of the county, but they continued to find that about 11 per cent of the cases tested need referral for further medical examination. A speech audiometer and two new portable audiometers have been purchased during the year. Most of the ear moulds made now are by the " cold cure " method, which enables the mould to be made entirely by our own audiometricians, and the children can receive these moulds the same, or the following day, thereby eliminating the long wait of some weeks. This was making a marked difference to the time that the child was without a hearing aid.

We were very sorry to see the failure in the supply of the strong Medresco OL58 and OL63 hearing aids during the year, and hope that these aids which proved so valuable to the severely deaf child will soon be available again.

The clinic at Hoddesdon which opened in October, 1969, was working very well, and provided our sixth centre for audiology clinics in the county. Seven audiology sessions are held in the county each week, and these were shared between the different centres.

There were 2 secretaries, 1 full-time and 1 part-time, who organized the appointments, dealt with enquiries, and typed the medical reports connected with these sessions. They also gave clerical assistance to the audiometricians. A new system for the duplication of audiograms has been of great help to the secretarial staff this year.

There were 2 courses for health visitors training, and 1 residential course of 1 week for the mother and child during the 12 months.

The liaison between the peripatetic teachers of the deaf and the Partially Hearing Units with the Audiology service continued to be excellent, thus enhancing the medical and educational help given to each hearing-handicapped child.

Report of the Adviser on Deaf and Partially Hearing Education, Mr. D. H. Grossman :—

The following were the numbers of children in the county at the end of 1970, sufficiently impaired in hearing to require the use of hearing aids, but not attending special schools for the deaf or partially hearing.

Division.	*Pre-school.*	*Infant schools.*	*Junior schools.*	*Secondary schools.*	*E.S.N., Ph.H. schools.*	*Partially-hearing Units.*	*Total.*
North Stevenage	8	0	9	19	5	16	57
East	6	1	12	12	1	18	50
Mid	7	2	7	10	0	0	26
St. Albans	6	2	9	8	2	24	51
South-West	7	1	16	11	10	16	61
Dacorum	5	2	8	12	1	0	28
	39	8	61	72	19	74	273

Children in partially hearing units are listed in the divisions in which they attend school. The 14 children who had hearing aids and attended Junior Training Centres were not listed above.

The overall total decreased by 16 on last year's figure. This was largely accounted for in the marked reduction in the number of hearing aid users in infant schools. I do not think any inference can be drawn from this one figure.

The number of children in partially hearing units increased by 7 due to the opening in September of an infant partially hearing unit in St. Albans. In addition there were a comparatively large and varying number of children with defective hearing in normal schools who did not need hearing aids but required occasional sessions of the advisory teachers' time. These children were usually

suffering from either slight bilateral conductive or severe unilateral sensori neural deafness, which could cause educational retardation unless their teachers were aware of the implications of such hearing losses.

Pre-School Children.

Two advisory teachers were employed in working with these children and guiding their parents.

A successful week's residential course was held at Balls Park College of Education in September for some of these parents and their deaf infants.

Auditory training units were available on loan to the parents of these infants.

Most of the older pre-school children spent some sessions each week in day nurseries, nursery schools, or play groups. We are grateful to their staffs for their co-operation and help with these children.

Partially Hearing Units.

A second unit, this one for infant age partially hearing children, was opened in September in Maple J.M.I. School, St. Albans. This increases the total of such units in the county to nine. Consideration was being given to the setting up of a secondary tutorial partially hearing unit in Stevenage during 1971.

The appointment of welfare assistants to help the teachers in charge of the Junior Units in addition to those in the Infant Units has proved worthwhile.

A conference for heads of schools in which these units are situated were held in February. It was considered sufficiently worthwhile to make this an annual event. On this occasion we were grateful to have the benefit of the guidance of Miss E. M. Johnson, H.M.I.

Plans were being made to explore the possible value of the use of closed circuit television in connection with this work.

Partially Hearing Children in Normal Classes of Ordinary Schools.

All these children were given help and their teachers guidance as necessary by advisory teachers of the deaf. We were delighted at the special interest shown by schools in these children, and the excellent co-operation they offered us.

Seminars for groups of class teachers who had partially hearing children in their classes were held in the Teachers' Centres.

The gradual introduction of the national health service post aural hearing aid has become very helpful, particularly to adolescents who were not always happy to use the body-worn type of hearing aid. Unfortunately it was not suitable, audiologically, for all children.

TABLE 45.—AUDIOMETRY TESTING, 1970.

(1)	*Screen Testing :*	
	(*a*) No. of sessions	273
	(*b*) Schools visited	215
	(*c*) Pupils tested	13,209
	(*d*) No. of children—normal hearing	12,270
	(*e*) No. of children—failed test	939
(2)	*Individual Audiometric Testing :*	
	(*a*) No. of sessions	412
	(*b*) Children tested—(Screen Test Failed)	668
	(*c*) Children tested—(Referred by M.O.s)	1,788
	(*d*) Children found to have hearing within normal limits	1,371
	(*e*) Children reported for further investigation	1,647
	(*f*) Children awaiting testing	231
(3)	*Audiology Clinics :*	
	(*a*) No. of sessions	308
	(*b*) Children tested	1,556
	(*c*) Ear moulds prepared for hearing aids	472

TABLE 46.—AUDIOLOGY CLINICS, 1970

	Clinics												
	Hatfield		Hemel Hempstead		Hitchin		Watford		St. Albans		Hoddesdon		Totals
No. of sessions	43		63		61		58		59		33		317
	School children	Others	School children	Others	School children	Others	School children	Others	School children	Others	School children	Others	
Attendances—													
New cases	48	28	67	80	47	49	46	56	51	36	36	39	583
Re-examinations	104	26	146	58	153	53	143	38	153	45	69	30	1,018
Total	152	54	213	138	200	102	189	94	204	81	105	69	1,601
Number of new cases reported as having—													
Normal hearing	18	14	44	64	21	37	15	29	19	20	13	23	317
Impaired hearing	21	4	16	5	21	2	26	5	19	4	13	10	146
Partial hearing	9	—	3	—	2	—	4	—	7	2	5	1	33
Severe deafness	—	1	2	—	1	12	—	1	2	—	5	1	15
Degree of hearing not yet known	—	9	2	11	2	8	1	21	4	10	—	4	72
Recommendations—													
Discharged	28	16	47	40	46	34	42	29	36	26	19	20	383
For follow-up appointments	124	38	163	105	156	65	148	48	167	56	84	49	1,203
Special schools/units	1	1	—	2	—	2	1	1	1	2	1	1	13
Auditory training	4	5	6	2	7	3	7	1	12	4	5	2	58
For educational psychologist I.Q. test	3	—	—	—	3	3	1	1	2	2	—	—	15
Referred ? Surgery	9	5	10	6	28	5	9	1	15	3	5	4	100
No. of hearing aids issued during year	10	—	5	3	11	3	8	—	14	4	6	3	67
Cases waiting first examination appointment	8	8	1	1	12	19	11	6	16	18	7	1	108

SPEECH THERAPY SERVICE.

There was an increasing recognition of the value to the growing child of the ability to communicate adequately with those around as delays or disorders in the acquisition of speech and language could have far reaching effects. It was therefore, in this connection not only very necessary as mentioned in earlier statements to ascertain and treat any deficiency in hearing, but also to deal quickly with any tendancy to defective speech. The causes of this condition are many, and can on occasion require the help of hospital consultants in different fields. However, in the majority of cases the therapists on the county council staff gave the required assistance to the child and the parents, and it was fortunate that notwithstanding an overall shortage of speech therapists in the country, there were in Hertfordshire some 26 speech therapists to the equivalent of 16½ full-time officers.

With the ever growing number of special schools and the greater attention to the handicapped possible in their smaller classes, the demands upon the speech therapy service have so increased that they have not yet been able to be met the extent desired.

Mr. Willmore, the Senior Speech Therapist, in his comments which follow alludes to this position and also the special units to which greater reference was made in last year's report.

TABLE 47.—SPEECH THERAPY CLINICS, 1970.

Clinics	Sessions	Attendances	No. of Children as at 31.12.70		Waiting List of new cases as at 31.12.70
			Under treatment	Under observation	
North Herts.					
Letchworth	92	631	23	3	1
Stevenage	296	1,390	47	84	19
Hitchin	154	835	45	7	2
Royston	66	371	14	2	—
St. Albans.					
St. Albans	336	1,657	47	80	20
Harpenden	115	478	15	30	16
Boreham Wood	86	297	20	29	3
London Colney	—	—	—	—	—
Dacorum.					
Hemel Hempstead	587	2,778	67	75	19
Berkhamsted	184	785	30	60	5
Mid Herts.					
Hatfield	118	409	13	25	—
Welwyn Garden City	320	1,926	58	68	2
Potters Bar	116	493	18	18	—
East Herts.					
Waltham Cross	48	262	9	13	3
Hoddesdon	163	978	35	30	6
Ware	246	1,671	54	39	15
Bishop's Stortford	75	464	18	23	10
Hertford	119	480	18	33	3
Cheshunt	123	769	32	38	9
South-West Herts.					
Watford	980	3,078	70	74	12
Rickmansworth	65	299	16	3	9
Oxhey	367	1,759	31	43	1
Totals	4,656	21,810	680	777	155

Mr. L. Willmore, Senior County Speech Therapist Reports :—

The Speech Therapy Service has been maintained reasonably well throughout the County.

In some parts it has not been possible to maintain the full requirements, particularly in some special schools. In a few areas therapy has not been always available except by attending clinics some distance from the children's homes. The staffing situation was constantly under pressure, but it was fortunate that a number of married therapists who lived in the county were able to offer assistance.

Two special units attached to primary schools in Hemel Hempstead and Stevenage for severe cases of speech and language disorders in young children completed their first two years in July. Some of these children had been transferred to other schools, but the need continued for further provision for a few older children in special units for communication disorders. Two such units were opened in September attached to Round Diamond Junior School, Stevenage, and Chaulden Junior School, Hemel Hempstead. Each of these units provided full-time special education and speech therapy for up to 12 children between the ages of 7 and 11. Transport was provided to bring the children to the units from their homes, thus making special help possible for children from a wide area.

In general, understanding of the needs of children with communication difficulties is becoming more widely recognized : doctors and teachers were referring more children to the speech therapy clinics, where they and their parents could be helped. Pre-school children, in particular, were now more often referred for assessment and guidance.

HANDICAPPED CHILDREN.

Whatever the result of the re-organization of the health services, there can be little doubt that children who are in any way handicapped must have due regard paid to their way of life, both at home and at school. It will have been seen earlier in this report that all possible steps are taken to ascertain the young children who are likely to require particular care, treatment or special educational facilities. The medical staff have for many years been attending refresher courses on all aspects of the development of children, and at the same time their contact with the paediatric consultants in the different hospitals has also increased quite considerably, the departmental medical staff have come to hold quite a unique position in relation to the handicapped child in the community.

In this connection, assessment clinics were held in health centres in many of the towns in the county whereby from babyhood up to 5 years children could be screened regularly to ensure that their progress followed along what was accepted as normal lines, further investigation through the family doctors was obtained at the appropriate hospitals when this seemed necessary. These assessment clinics provided a more intensive survey of a particular child's physical and mental state than was possible in the bustle of an ordinary infant welfare centre.

Dr. Gardiner, the deputy divisional medical officer in the Dacorum division, has given a very comprehensive report on the activities in this field in that division, and although actions of a similar kind had not been possible in all divisions in the county, the report does show the importance attached by the members of this department as a whole to the overall need to look at every child as an individual who may or may not require particular attention to some facet of his or her development.

TABLE 48.—HANDICAPPED PUPILS. SPECIAL CLASSES AND UNITS.

Unit or Class	No. of	Number of Children in Attendance as at 22.1.71						
		North	East	South West	Mid	Dacorum	St. Albans	Totals.
Partially hearing .	9	16	18	16	—	—	24	74
Emotionally disturbed and retarded . .	21	56	22	29	24	18	25	174
Speech defective .	4	20	—	—	—	15	—	35
Physically handicapped .	1	—	—	18	—	—	—	18
Totals . .	35	92	40	63	24	33	49	301

Table 49.—Handicapped Pupils, 1970.

Category	During the calendar year ended 31.12.70		As at 21st January, 1971 No. of Children Receiving Special Educational Treatment								Waiting lists 21.1.71		Totals
	New cases assessed	New admissions	Special schools Day	Special schools Res.	Independent schools	Boarding homes or hostels	At home	Units and classes	Hospitals	Total	Day	Res.	
Blind	2	2	—	17	—	—	1	—	—	18	—	—	18
Partially Sighted	7	5	19	11	1	—	1	—	—	32	1	2	35
Deaf	6	8	7	34	35	—	1	—	—	77	—	3	80
Partially Hearing	3	6	2	18	—	—	—	76	—	96	—	—	96
Physically Handicapped	25	25	68	39	21	2	10	18	8	166	2	3	171
Delicate	19	13	3	32	5	1	2	—	—	43	—	4	47
Maladjusted	89	86	23	175	149	10	29	174	24	584	2	34	620
Educationally Sub-Normal	267	255	1,142	96	24	—	2	—	12	1,276	43	2	1,321
Epileptic	3	4	—	12	—	—	1	—	—	13	—	—	13
Speech	—	1	—	2	—	—	—	35	—	37	—	1	38
Totals	421	405	1,264	436	235	13	47	303	44	2,342	48	49	2,439

THE PROBLEM OF HANDICAPPED CHILDREN IN THE DACORUM DIVISION OF HERTFORDSHIRE.

By Dr. S. J. Gardiner

With the undoubted rise in the incidence of handicapped children in the country, due to the rise in population (Dacorum Division—1961—94,046—1970—112,500), the prolongation of life by antibiotics, the improved medical knowhow, and the earlier detection of handicapping conditions through more precise assertainment, it might be timely to determine the extent of the problem of handicapped children in the Dacorum Division, and to what extent our medical services are adequate to meet the demands of an ever increasing need.

The Seebohm report and its implications should stimulate us to define the extent of the present medical coverage of handicapped children, to find the gaps and loopholes in the service, and to attempt to streamline and co-ordinate the methods in use at present, so that we improve our already existing framework of medical care for all handicapped children.

The transfer of the Junior Training Centres to the Department of Education and Science, should also alert us to the need for a well-directed and constantly co-ordinated medical review and follow-up of the children in these centres, comparable at least to that given to children in normal schools. Let us attempt to establish as foolproof a framework of medical care in the health department, which in conjunction with our hospital and general practitioner colleagues, through early detection, screening, assertainment, and referral for treatment, therapy, care, training, and education, will present a medical service for the handicapped child which in the future, no matter what changes occur in the National Health Service, cannot be ignored or bypassed, or easily disintegrated, no matter under whose auspices it may be required to function. Let us make sure that the child's medical needs are met and not overlooked through ignorance and complacency and lack of time, and let us make sure that these needs are served by those with the knowledge and skill to diagnose them. Medical officers in health departments, who are worth their salt at all, have always been social workers as well as medical advisers, and have had the help of health visitors in much of the social work of the past. It is regrettable that Seebohm has given such scant praise to health visitors who have been case workers for years, and whole-family orientated because of the nature of their work and their close contact with the family in the home.

The precise incidence of handicapping conditions in the country is unknown, but according to the latest reports available from the Dept. of Health the following estimates are given for school children :—

In England in 1968 (The Health of the School Child 1966–68 Report of Chief Medical Officer for Department of Education and Science) there were considered to be 101,128 children at school *requiring Special Education* i.e., 14·158 per 1,000 live births. On this basis with a school population in the Dacorum Division of 23,286, approximately 330 children may require Special Education. Actually 396 are having special education.

Table 1.—In England in 1968.

	Nos.	*Per 1,000 live births.*
Physically handicapped	11,232	1·572
Educationally sub-normal	57,895	8·105
Severely sub-normal (training centres)	31,600	4·000
Epileptic	819	0·115
Maladjusted	11,064	1·549

Incidence rates for pre-school children are not easily available, due to the ever changing position with regard to these children on the handicapped and observation registers. It is not until 5 to 7 years of age in many instances that

a true estimate of the permanent outcome is available. However, an attempt will be made to estimate the position with regard to the handicapped child in this Division for both pre-school and school age groups.

Medical Responsibility.

The medical responsibility in dealing with handicapped children is threefold in nature. In the first place the doctor must be on the look-out for handicap, so that he can detect it at the earliest possible age, and refer the child for specialist opinion and advice as to what can be done to overcome, or at least ameliorate, the disability. In this regard the increased recognition of the value of developmental paediatrics, and the formation of a district developmental assessment unit under the general supervision of a consultant paediatrician as is the case here is a welcome advance towards earlier detection and referral. Secondly, the doctor involved in the care of the handicapped, must know of the organizations, voluntary and statutory, which are available to help these children. The local authority medical officers are in a privileged position in this respect. Thirdly, there is the supervision, follow-up, review care of the child in the home, Playgroup, Nursery, Junior Training Centre, or School. This latter service can be shared by the general practitioner and the Local Authority medical officer, with the latter acting as liaison between patient, general practitioner and Hospital and any caring organization whose services—medical, nursing or social, may be required by the patient.

Handicapped children have a deep longing to achieve as much independence as possible within the normal community, and no one is better qualified to aid them to achieve this than the medically trained person with his knowledge of the modern advances in curative and preventive medicine and his practical approach to the problem.

All too often in the past, particularly in the case of the deaf child and the spastic child, has diagnosis been delayed until it is too late, to ensure the child's disability is overcome to the maximum extent. It was in an attempt to overcome this that the " At Risk " Register or Obersvation Register was established in many areas. Such registers have much to offer if they are " live " registers and used judiciously, but in all too many departments they are not. It must always be remembered that to be effective the register must hold 10–12 per cent of the births only, and that between 30–60 per cent of handicapped children have not been on the " At Risk " register. So careful thought and control is required to make them viable records and a really effective contribution to the control of the problem.

The problem of the handicapped child weighs heavily on the general practitioner not because his case load is so great, but because of the continuous responsibility and the time involved with each child and his parents. In many ways family doctors and infant welfare medical officers, who see the children from the very earliest weeks of age, are the keys to success. It is their vigilance that can find the handicapped child at an early age, and their counsel that can guide the parents through the difficult period of adjusting to the fact that they have a handicapped child. It is the doctor who is the prime mover in assuring that everything possible is done for the child. Thus the closest links must prevail. The departmental medical officer, who may have been fortunate to have had extra training and experience in dealing with these children, can be of invaluable help to the general practitioner and should make every attempt to discuss the child with him and extend an offer of practical help. At present other commitments prevent this from being done in all but a few instances.

The Needs of Handicapped children include the following :—

1. *Early Detection.*

Increasing attention is now paid to the health and development of the foetus as a result of greater interest in antenantal paediatrics. Routine medical

examination including a neurological examination of all new born babies, is essential to recognize handicap early, so that the necessary treatment can be instituted as soon as possible. Recent evidence suggests that cerebral palsy, mental retardation, defects of hearing and vision are capable of far earlier detection, than at the stage which gives rise to gross deviation from normal function. Now that a developmental assessment unit has commenced here, assessments are being made by a departmental medical officer, at the request of general practitioners and hospital staff, on all children who are regarded as being delayed in reaching the normal developmental milestones, and it is hoped that children will be sent forward at as early an age, before two years if possible, so that a full future programme of treatment, care, and education can be planned well before school entry.

After screening by the local authority doctor who then confers with the local paediatrician the child may go to hospital for fuller clinical paediatric investigation, or he may be admitted to a play-group or to the junior training centre, referred to a speech therapist, or to another consultant.

It is hoped that a further extension of the developmental assessment unit can be made to include the babies from the special care unit in the maternity hospital, and that regular checks will be made on them at frequent intervals during the first two years.

Home screening and ascertainment is often also desirable for families living at a distance and who may find it difficult to attend the assessment unit at Hemel Hempstead. Many children may require to be followed up and perhaps reviewed and assessed. For this, time must be set aside. It is desirable also that children placed in nurseries and play groups be reviewed with the teaching staff at regular intervals.

2. *Specific Screening Test.*

Specific screening tests at birth are now carried out for phenylketonuria and congenital abnormalities. Screening for hearing is also being undertaken by health visitors on all babies about 8–9 months, the age at which the child is able to discriminate local sounds. Deafness is about 14 times commoner in the " At Risk " baby, but testing of only those in this category, is likely to leave about one-third of significantly deaf children undetected, so the effort to screen all babies is well worth the time and touble.

3. *Vision Testing.*

At the present time many children are reaching school age with untreated defects in visual acuity, with or without squint. The Stycar Test, a letter and toy matching technique, has been found useful and not only in mentally retarded and language delayed children, but also for routine screening of very young children. At present the Stycar Letter Test is used routinely by health visitors in this division on all school entrants, but it is desirable that this technique should be used at an earlier age if possible. It is quick and easy and we should be able to introduce it for routine testing from 3 years onwards by medical officers and health visitors. Detection of squint in young children is not always easy but if there is any suggestion of doubt, prompt referral for consultant opinion should be made.

4. *Comprehensive Assessment.*

A fair amount of developmental paediatrics has been carried out in this division for some years, but we are in process of introducing a more organized and routine approach to our examinations so that all babies are covered.

All babies are invited to the clinics for a medical examination at 6 weeks by the clinic doctor. Birthday checks at 1 year and 2 years are also carried out by clinic doctors.

Health visitors are being introduced to the methods of developmental testing of babies, so that they can do the developmental examinations at 6

months and 18 months to assess any delay or defect which may be noticeable before the next medical check is due. It is important that health visitors undress babies and observe for themselves what the child can do, rather than accept the mother's word for the child's ability. It is hoped that the health visitor will also examine babies of 6 weeks who do not attend the clinics and continue to examine such babies at the recognized times. Progress charts with detailed norms for ages—6/52, 6/12, 1 year, 18/12 and 2 years—are in use for this purpose.

At present health visitors are being trained to assist the doctors in this very important work, and it is foreseen that this earlier detection will throw up a greater number of children to be screened and assessed at the developmental assessment unit. The importance of comprehensive assessment of handicapped children has been recognized in recent years. It has been underlined by the frequency of multiple handicaps, mental and physical, and the difficulty in making a complete evaluation of a child's abilities and potential. Obviously no one person can hope to possess the range of skills and the necessary multi-disciplinary approach to the problem that comprehensive assessment requires. The Sheldon Report on the Child Welfare Centres in 1967 states that early detection of physical, mental, and emotional defects is a major function of a modern preventive child health service and this is what we are attempting to achieve here, by bringing our health visitors into active participation in this field. The interest and enthusiasm of the health visitors must be aroused, fostered, and sustained by the departmental medical officer, whose job it is to lead the way. More training is also desirable for all concerned in this work, and, more time must eventually be allotted for it.

In May, 1971, an in-service training course of 12 sessions has been arranged for all departmental medical officers in Hertfordshire, to which some of the principal experts in developmental paediatrics in the South East have been invited to give lecture demonstrations. This is a start to the organized training of staff in this field, and it is timely that it should be taking place now, when public health is at the watershed of its activities.

District Assessment Unit.

Here a district Assessment Unit is in operation, and the child's family doctor and health visitor are both brought into the assessment of the child. The corner-stone of a successful community service for the handicapped child is a close working medical partnership between consultant paediatrician and the local authority medical liaison officer with particular experience in handicapped children. The latter should enhance the work of the assessment service with specialist knowledge of local services and conditions, and bring together the contributions of other officers of the local authority for any particular child.

Again it is envisaged that more time will be required by the liaison officer for comprehensive screening and assessment and direction of a concerted medical policy in respect of the handicapped child, so that overall awareness is maintained. Also more individual work at a day-to-day level on each child concerned is necessary, so that an endeavour is made to learn the exact state of the child's medical care and stage of investigation, so that complete liaison and follow-on is achieved at the various disciplinary interfaces. Time must be allotted for the medical review of childrens' case histories, also time to relate with the health visitor, the general practitioner, the speech therapist, and the education psychologist and any other person involved to ensure the uninterrupted and undelayed progression of the child through the various and necessary screening, investigation, therapeutic training and teaching areas, so as to enable him to make the best of his abilities.

It is necessary for the liaison officer to have senior status if he is to rate as a specialist in the community health field, and communicate as an equal with other specialists in this field.

It is convenient to consider handicapped children in 4 broad groups, but not separate categories :—

1. Congenital Malformations
2. Inherited conditions
3. Cerebral Palsy
4. Mental Handicap.

These groups indicate the wide ranging types of common handicapping conditions and combinations of them.

1. *Congenital Malformations* result from faulty structural development at any stage of pre-natal existence.

Table II.—Comparative Rates per 1,000 live Births in 1965 and 1967.
(Annual Report of Chief Medical Officer for 1968).

	England and Wales.		*South East England.*	
	1965.	*1967.*	*1965.*	*1967.*
Anencephalous . . .	1·537	1·477	1·096	1·304
Hydrocephalus } Spina Bifida } . . .	2·462	2·511	1·918	2·145
Cleft lip, Cleft palate . .	1·314	1·386	1·330	1·457
Talipes	3·622	3·95	3·462	3·659
Exomphalos . . .	·267	·288	·237	·285
Mongolism	·658	·726	·614	·715
All malformed babies . .	15·79	16·647	14·416	16·937

These figures show an increase in congenital malformations in the 3 years—1965–67.

Spina Bifida—Prevalence rate for England 1·73 per 1,000 (2,600 under 5 years with Spina Bifida in England in 1968).

Spina Bifida is a striking example of how the multi-handicapped child requires extensive medical, social, and educational help, and of the difficulties facing the child himself and his family. Where previously 95 per cent of these children died, now with modern surgical methods about 75 per cent survive, and make a partial or complete recovery. 56 per cent have a 5-year survival and 71 per cent of the survivors are mentally normal and of these 27 per cent have no other physical handicap and attend ordinary school. 19 per cent of survivors are E.S.N. and 10 per cent S.S.N.

2. *Inherited Conditions.*

More is becoming known about diseases determined by hereditary influences, which are transmitted by dominant, recessive, and sex linked inheritance and the abnormal chromosomal patterns associated with specific abnormalities.

Recessive inherited conditions are an important group. Phenylketonuria like other inborn errors of metabolism is due to a recessive gene. It was found in 1 in 20,000 births before the more sensitive Guthrie Test was used. More are now being discovered with the introduction of this test.

3. *Cerebral Palsy.*

Cerebral Palsy continues to be one of the major disabilities of childhood. Incidence of 1–2 per 1,000 live births. Estimates of prevalence vary, partly due to differences in definition and methods of case finding. In 1964—2·5 per 1,000 live births school children in Scotland, 2·9 per 1,000 live birth children aged 8–10 years in the Isle of Wight. No cause for cerebral palsy is found in 50 per cent cases.

4. *Mental Handicap.*

Children with mental handicap constitute an important group. Many handicapped children have both mental and physical defects.

50 per cent have abnormalities of the central nervous system. Mentally subnormal children in borderline range I.Q. 60–75 whether brain damaged or not are almost entirely of lower working class origin, whereas severely subnormal children, I.Q. <50, show no social class gradient. There has been a marked rise in mental subnormality over the last decade.

Pre-school Handicapped Children.

The number of live births (corrected) for the Dacorum Division during the years 1966–70, inclusive was 9,070. On the last day of 1970—357 of the children were on the handicapped register, and after review of summary cards on each of these 357 children, it was considered that 104 of them required constant medical review and follow-up to assess their residual handicap and their special needs for educational placement. Of these 104 there were 10 children attending the Junior Training Centre, 20 attending the Manor Street play-group for handicapped children in Berkhamsted, and another 20 attending various play-groups throughout the division. All ranges of handicap are catered for, from asthma, and coeliac disease to hydrocephalus, spina bifida, mongolism and convulsions. It was also found that 34 children with difficulties such as speech defects, enuresis and asthma were attending play-groups, but were not on the handicapped register. This estimate of 104 children is a conservative one, and it is probable that many others, at present under hospital care, will in future need to be included under the umbrella of the Assessment Unit.

Table III.

Year.	*No. of live births.*	*No. on Handicapped Register.*	*Requiring regular follow-up.*
1966 . .	1,816	65	21
1967 . .	1,794	86	36
1968 . .	1,894	93	32
1969 . .	1,806	67	11
1970 . .	1,756	46	4
	9,070	357	104

Divisional Play-group for Handicapped Children at Berkhamsted.

This play-group was started in January, 1970, from small beginnings but with much enthusiasm. It has slowly evolved from catering for 5 children, and a reluctance by parents to accept it as suitable for their children, to up to 21 children and an increasing recognition by parents of the benefits to be gained.

Initially it began with a firm determination on the part of the departmental medical officer that it should succeed, and an enthusiastic response from local voluntary helpers. In July, 1970, a whole-time teacher with nursery class experience was appointed and the play-group really began to prosper. Fortunately the response for voluntary help, was able to be obtained from time to time, and with skilled manipulation of the staff rota, adequate help was maintained. Toys and apparatus have been supplied by both the County Council, and by handsome donations from private sources. Indeed the success of the play centre is truly the success of mutual aid and understanding between official and voluntary workers.

The doctor for the centre assesses the children before admission, determines the admissions and supervises progress with the teacher.

All handicaps, whether physical, mental, emotional, or social are catered for and it is the policy, with the agreement of the staff, to admit any age under five years. The provision of transport allows children from a distance to be admitted, and allows of a more timed programme to be maintained.

The provision of play-group places for handicapped children is by no means met as yet, remembering it is such children who need help and training the most.

Undoubtedly the developmental assessment unit has uncovered the needs of many more children, who would benefit from earlier training.

The final stage in the present development was the establishment of a discussion group for parents of the children, lead by a social worker, and which meets weekly. We have come a long way from the lowly beginning of a child minding service in January, 1970.

Table IV.—The specific handicaps of children admitted to the Berkhamsted Play Centre for handicapped children during 1970.

Cerebral Palsy	1
Deafness (hearing aid)	1
Cleft Palate and Hare Lip (speech delay)	1
Exomphalos : Tracheal Stenosis	1
Congenital absence of right jaw and hearing loss	1
Treacher Collin's Syndrome (neuro-developmental disorder)	1
Mongolism	2
Severe Retardation	1
Mental and Physical Retardation	2
Social deprivation and Global Delay	2
Global Delay alone	2
Speech delay alone	3
Emotional Maladjustment	5

Disposal on discharge.

Transferred to another nursery	2
Transferred to Junior Training Centre	2
Left area	2
At home—not attending a play-group	3

Table V.—An analysis of the handicapping conditions of the 357 pre-school children on the handicapped register.

	No.	Rate per 1,000 live births.
Congenital Malformations—211.		
Hydrocephalus and Spina Bifida	15	1·65
Hare Lip and Cleft Palate	9	0·99
Talipes	32	3·4
Mongolism	5	0·55
Cardiac defect	32	3·4
Congenital dislocation of hip	78	8·6
Congenital Cataract	5	0·55
Various other abnormalities	35	3·9
Inherited Conditions—26.		
Epilepsy	2	0·22
Convulsions	7	0·71
Still's Disease	1	0·11
Coeliac Disease	5	0·55
Spinal Curvature	1	0·11
Diabetes	1	0·11
Asthma	1	0·11
Nystagmus	3	0·3
Wilm's Tumour	1	0·11
Niemann Peck's Disease	1	0·11
Hydrocele	1	0·11
Cirrhosis of Liver	1	0·11
Calcium deficiency	1	0·11
Cerebral Palsy	12	1·2
Mental Defect (no. including Mongols)	41	4·5
Deafness	7	0·71
Others	6	0·66
Children of Problem Families	32	3·4
Children of Parents with Mental Illness	22	2·4

The accuracy of the incidence rates of the various handicapping conditions in the pre-school child will always be in question, as this depends on the standards of medical knowhow in the area, the interests of the staff, the facilities available for diagnosis, and the proximity to a large teaching hospital.

Table VI.—Handicapping conditions in school children in Dacorum Division—school population—23,286 in 1970.

The following estimate of the handicapping conditions has been compiled from the register kept in the department for all school children who have an illness, defect, abnormality or handicap, which could possibly affect their progress in school.

Educationally Sub-normal	186
Severely Sub-normal	50
Maladjusted	35
Deaf	15
Partially hearing	14
Blind	5
Partially sighted	17
Physical Defects.	
Congenital Heart Defect	44
Cerebral Palsy	24
Asthma	15
Spina Bifida	14
Perthe's Disease	14
Epilepsy	9
Orthopaedic Defects	10
Diabetes	9
Congenital Cystic Fibrosis	8
Deformities of hands and feet	7
Congenital dislocation of hip	7
Still's Disease	6
Dwarfism	6
Post Polio	6
Renal Disease	6
Hemiplegia	4
Talipes Equino Varus	4
Phenylketonuria	4
Congenital dual stricture	3
Haemophilia	3
Haemolytic Anaemia	2
Splenectomy	2
Crossed Lateratily	2
Thalassaemia	2
Single Kidney	2
Autism	1
Thalidomide Defect	1
Perineal Muscular Atrophy	1
Post Burns Effects	1
Congenital Pyloric Stenosis	1
Hypoglycaemia	1
Hirschsprung's Disease	1
Congenital Defect of Spine	1
Congenital Hypotonic Spinal Musculature	1
Amputation	1
Arthrogryphosis	1
Muscular atrophy	1
Muscular dystrophy	1
Congenital shortening of Achilles Tendon	1
Partial collapse of lung	1
Chorea	1
Sickle Celled Anaemia	1
Tuberculosis	1
Coeliac Disease	1

Total number of children with physical defect = 250.

Only 65 of these children are considered to be officially handicapped, and only 23 of them attend special school. This is because there is perhaps more latent illness in school children than we are prepared to consider officially. These defects, illnesses, abnormalities are a potential source of hindrance to school progress and may be unknown to teaching staff, and given scant recognition by those concerned. These illnesses must be made known to the teachers concerned.

Official Incidence Rate Physically Handicapped—65 in 23,286 school children gives 2·8 per 1,000 live births (1·572 per 1,000 live births is rate for England). An analysis of these 65 conditions is given below in Table VII.

Table VII.

		Normal School.	*Special School.*
Cerebral Palsy	24	10	14
Spina Bifida	11	6	5
Congenital Malformation	10	8	2
Congenital Heart	3	2	1
Kidney Disease	3	3	
Still's Disease	5	5	
Perthe's Disease	3	3	
Phenylktonuria	4	3	1
Thalassaemia	2	2	
	65	42	23

Cerebral Palsy.

Total number of children with Cerebral Palsy : 12 pre-school, 24 school =36. i.e. 36 in child population of 32,356 = 1·11 per 1,000 live births. (Rate for England 1·2 per 1,000 live births.)

Cerebral Palsy accounts for the largest number of physically handicapped children in Special schools. Educational provision has increased greatly over the last 20 years.

Spina Bifida.

Total number of children with Spina Bifida : 15 Pre-school, 14 School = 29. i.e. 29 in child population of 32,356 = 0·9 per 1,000 live births. (Rate for England 1·73 per 1,000 live births.)

These children require continuous medical supervision, treatment, and support in paediatric assessment centres and suitable medical and educational provision from 2–3 years. 40 per cent survive until school age.

In 1969, of the 15,000 children who spend over 4 months in hospital—12·4 per cent suffered from Spina Bifida and 8 per cent suffered from Cerebral Palsy. (Figures given by Dr. E. M. Ring—Principal Medical Officer to Department of Health and Social Security.)

Severely Subnormal Children.

The Junior Training Centre in Hemel Hempstead established 16 years ago is to become the Woodfield School, and under the management of the Education Department of the County Council. It is very unlikely that the present procedures for ascertainment, and admission and discharge will be altered, because of the change of management.

Diagnosis and ascertainment is a lengthy procedure involving many skills and disciplines, but as the procedure is largely common to all local authorities it will not be described here.

Admission to the school is usually through an admission panel consisting of headmistress of the school, a senior social worker, and senior medical officer, although emergency admission can be recommended by headmistress after conferring with the medical officer.

The school is divided into three sections, the special care unit, the pre-school section and the normal school for children over 5 years. The special care unit includes children of all ages 3–16 years with dual or multiple handicaps, the majority of whom are unlikely to prove educable and whose ultimate future, when parental care is no longer possible rests upon permanent hospital placement. It may also include children with a dual handicap who may in time progress on to the school proper.

Children in the special care unit require a lot of medical attention in addition to the normal care provided by the school staff, some of whom have nursing training. A close liaison must be kept with the family doctor, as many of these children are on drugs, and for the correct dosage of which the family doctor must rely to a certain extent upon information about the child's behaviour in school. For this purpose the school doctor must attend frequently to assess for herself the behaviour of the children and to discuss with the headmistress those facets which perhaps indicate a revision of the drug therapy.

With the exception of mongols, pre-school-aged children are usually admitted after examination at the developmental assessment unit. Many of these pre-school children have been already attending the special playgroup established for handicapped children, or perhaps a normal play-group, and the child and parents are well-known to the doctor before admission.

The children in the school proper do not usually require extra medical attention, and although they are regularly observed by the school doctor, the staff, in most instances, can manage without much medical support.

The special care unit was established only some five years ago, and already it is recognized that more accommodation is needed and indeed plans have already been made for its provision at the site of the present school. In the meantime those children capable of receiving benefit from early training are being admitted to the play-group for handicapped children. The more severely affected children must await the provision of the new accommodation.

It is a measure of the quality of service in the Woodfield school, and now also in the play-group for handicapped children, that few parents consider it a stigma to send their children to these centres. It also reflects the success of the divisional assessment unit, that more children are being brought forward at an earlier age for admission and help.

Table VIII.—Total Estimated Number of S.S.N. Children in Dacorum Division.

Under 5 years in Woodfield School	10
Over 5 years in Woodfield School	50
Under 5 years in Divisional Handicapped Play-group	6
Under 5 years in other Play-groups	4
Under 5 years at home	24
Outside of Division (and school age)	6
	100

i.e. 100 in population of 32,355 children (pre-school and school) = 3·1 per 1,000 live births (4 per 1,000 is Rate for England).

The figure of 3·1 per 1,000 live births can be only an approximation because some of the 24 children under 5 years at home have not been assessed and only a clinical estimate has been made. Also others may reveal themselves as school age approaches.

Educationally Subnormal Children.

Children with Learning Difficulties.

The term " educationally subnormal " was first introduced in the Handicapped Pupils and School Health Service Regulation 1945, and has met with increasing criticism. Educational backwardness should not be regarded as a single, sharply defined characteristic, as was mental deficiency, but rather as a matter of degree and origin and caused by a combination of circumstances.

In practice the term " educationally subnormal " is too often restricted to children who are considered to need full-time education in a special school principally because of educational backwardness, associated with lower than average I.Q. However, educationally subnormal children include both those

who are backward, whether or not they are mentally retarded, and also children of average and above average ability who for various reasons, are educationally retarded, i.e. their attainments are not commensurate with their ability. It is the departmental medical officers' job to find out if this is so and why. He must diagnose the cause of the child's backwardness, in the light of which he can advise both the teacher and the local education authority. Much can be done in the pre-school years by vigilance in the infant welfare clinics. Children with speech delay, poor co-ordination and poor concentration, hyperactivity, emotional difficulties, social and maternal deprivation, and global delay in development, should be regarded as potential slow learners. Help, by learning through play, should be given at as early an age as possible. The age at which a child is admitted to a nursery or play-group will vary with the circumstances of each child, but the assessment prior to this should take place as early as possible and preferably not later than 2–2½ years. Frequently children are found to be functioning at a level many months behind the average for their chronological age, not due to a defect in basic intelligence, but due to the lack of parental stimulus, and opportunity to learn.

It is regrettable that the conception of handicapped is so markedly biased to the physical and mental aspects of a child's make-up. Many children who find themselves in E.S.N. schools and classes for the maladjusted are of normal intelligence. In infancy they have been socially, emotionally, and maternally deprived. Had help been given in the pre-school years their transition to normal school from play-groups in many instances would have been assured. Much use has been made of the divisional play-group for handicapped children, for such deprived children, who seem always very insecure and require extra attention and above all affection. The majority of them have no idea how to play either alone or in playgroups, but they all respond well to organized activities like movement, verses, and mime. Following a simple instruction such as " close the door " or " put the doll in the cot ", is impossible for most of them, even at the age of 4 years. It may appear that a child is deaf, when in fact he just does not comprehend what he is being asked to do, because he has not related in this way previously to anyone. Some are tense and highly strung, with the gaze darting about hither and thither, almost fearfully. The majority are very retarded in speech, and will merely grunt in reply to a question. Some will not even do that. Many are stilted and immobile, and even at 4 or 5 years cannot hop or jump. They are unable to relax, and even walking makes them look awkward and clumsy. Such deprived children do not seem aware of what goes on around them. Their home background is such that even pictures of common objects like trains, buses, animals, etc., seem strange and unfamiliar. No-one speaks, reads or sings to them ; they come from an inadequate home background. In some cases the mothers of these children are young and inexperienced, with several children, and have not the time nor inclination to cope with the child as an individual. It is this individuality that seems to be lacking in these deprived children, who need someone to play and learn with them in a happy, secure, ordered atmosphere to help them to develop into normal well-adjusted human beings. The nursery play-group provides this atmosphere and help.

In 1951, in England and Wales the prevalence of E.S.N. children was 5·1 per 1,000 and in 1968 it was estimated at 8 per 1,000 school children. Attempts must be made to investigate and stop this upward trend, with help and training given at an early age. In this way these children who are backward, but not mentally defective can be given an opportunity of attaining their inherent potential, and attaining places in normal schools. The first 7 years of a child's life are the formative years, and the opportunity for learning during these years, if omitted, can never be replaced.

There are 157 children between 5–16 years attending Collett Special School in Hemel Hempstead for E.S.N. children in the division. There are 11 children on the waiting list for admission, and waiting time may be up to 6 months. At school outside the division there are 12 E.S.N. children.

Table IX.

Number of E.S.N. School children.

In Collett School	157
At school outside the Division	12
P.H. and E.S.N.	11
On waiting list for Collett	11
	191

191 in 23,286 school children = 8·2 per 1,000 live births. (Rate for England = 8·1 per 1,000 live births.)

Number of Mentally Subnormal School children.

E.S.N.	191
S.S.N.	56
	247

247 school children in school population of 23,286 = 10·6 per 1,000 live births. (Rate for England = 9·1 per 1,000 live births.)

Maladjusted Children.

Children with emotional problems are considered as handicapped both socially and educationally. Emotional maladjustment can develop at any age, and an awareness of the various stresses and pressures which children from the very earliest, can be subjected to, is an essential part of the diagnostic equipment of those dealing with children. The medical officer must be prepared to give time to confer with teachers and parents to discuss the emotional problems of their children.

In an attempt to help such children, an after school play club has been formed in Berkhamsted to which are invited children between the ages of 5 and 11 years, who have been brought to the notice of the school medical officer.

This club meets once per week after school in the premises used for the play-group for handicapped children. It is in the charge of a voluntary worker, a mother of two teenagers who was a teacher with special training in nursery methods.

The idea first stemmed from the desire of the school medical officer to help asthmatic and enuretic children. The thought of releasing tensions by free play such as dressing-up, acting, painting, baking, sand and water play, football, etc., seemed a good idea, while awaiting the more sophisticated methods of the Child Guidance Service to take over.

The Club has been operating for only a few weeks, and 10 children arrive promptly each Wednesday, eager to embark on these extra curricular activities. Changes have already been observed in the children's attitudes and behaviour, and also in the involvement of some of the parents. All materials used in the various activities are at present donated by the teacher, parents, and friends of the club.

In the division, Boxmoor House School in Hemel Hempstead, admits severely maladjusted boys from the Dacorum division as well as other parts of Hertfordshire. 10 boys between the ages of 10–16 years attend from the division, while the school caters for 60 residential and day boys.

Another 20 maladjusted children attend special units in 3 normal schools in the division and 5 children are in residential schools, outside the division.

All placements are made after consultation and ascertainment by the Child and Family Psychiatric Service. The boys in Boxmoor House School are visited regularly by a consultant psychiatrist and are in the care of experienced teachers in the field, and psychiatric social workers. Only the strictly medical care comes into the orbit of a school doctor of the division.

There are 35 maladjusted school children in the division requiring special

education at present. This gives an incidence of 1·5 per 1,000 school children. (Rate for England is 1·54 per 1,000 live school children.)

Epilepsy.

2 pre-school children and 9 school children are known to suffer from Epilepsy of the Grand Mal type.

i.e., 11 children in 32,356 child population gives an incidence of 0·37 per 1,000 as compared with 0·12 per 1,000 for England.

Blind and Partially Sighted.

There are 5 blind children in the division all attending schools outside of Hertfordshire.

There are 17 partially sighted, 7 of whom attend normal school in the division, 2 attend special classes of a physically handicapped unit of a normal school, and 8 attend schools outside the division.

An attempt is made to interview the parents and examine these children yearly.

Incidence of blind	0·11 per 1,000 live births.
Incidence of partially sighted . .	0·73 per 1,000 live births.

(Rate for England = Blind 0·17 per 1,000 live births.) (Rate for England = Partially sighted 0·3 per 1,000 live births.)

Deaf and Partially Hearing.

There are 15 deaf children attending schools outside of the Division and 14 partially hearing children, 5 of whom go to normal schools in the Division.

Incidence of deaf	0·64 per 1,000 live births.
Incidence of partially hearing . .	0·6 per 1,000 live births.

(Rate for England = Deaf 0·45 per 1,000 live births.) (Rate for England =Partially Hearing 0·51 per 1,000 live births.)

Special Units for Children with Speech Defect and Delay.

Gade Valley Infants . .	5 children
Chaulden Junior . . .	4 children

There are 2 special units in Hemel Hempstead for children suffering from severe speech defect or delay, usually in association with other conditions.

i.e., 9 children in 23,286 school children receive special education because of speech defect.

i.e. 0·38 per 1,000 (Rate for England 0·03 per 1,000).

Table X.—Comparison of Rates of Handicaps in Dacorum Division with Rates for England (per 1,000 live births).

	Dacorum Division.	*England.*
Physically handicapped .	2·4	1·57
S.S.N.	3·1	4·0
E.S.N.	7·7	8·1
Epileptic	0·39	0·12
Maladjusted . . .	1·5	1·5
Blind	0·11	0·17
Partially sighted . . .	0·73	0·3
Deaf	0·64	0·45
Partially hearing . .	0·6	0·51
Speech defects . . .	0·38	0·03
Cerebral Palsy . . .	1·11	1·2
Spina Bifida . . .	0·9	1·73

For certain conditions Table X shows a marked discrepancy in the incidence rate between the Dacorum Division and England.

It should be noted firstly that Hemel Hempstead is a designated new town, and it is probable that at least half of the population are immigrants from many industrial areas in the country, principally London.

In the instances where the prevalence in the division is higher than that for England generally it could be postulated that the level of local expertise and the proximity to teaching hospitals in London may be the reason.

The differences in individual doctor's assessment of the degree to which a condition is estimated to handicap a child at school, may explain the higher incidence for physically handicapped.

In the case of spina bifida the incidence is almost half that for England. The reason for this does not readily come to mind.

References for Incidence Rates taken from :—

1. The Health of the School Child 1966–68, by Chief Medical Officer for Department of Education and Science.

2. On the State of the Public Health by Chief Medical Officer of Department of Health and Social Security for the year 1968.

Conclusions.

1. Handicapping conditions are on the increase.

2. The District Developmental Assessment Unit is revealing more delayed and handicapped children at an earlier age, and the need for early placement for training and socialization, as well as investigation and follow-up, is apparent.

3. More pre-school nursery accommodation for such handicapped children is urgently required. On the whole pre-school children with physical handicaps are better catered for than those with mental, emotional, and social handicaps.

4. There must be early referral to the District Assessment Unit, preferably before 2 years of age of children known to be handicapped and also children who are delayed in reaching their developmental milestones.

5. Intensive practical training of medical officers in Department is required in developmental paediatrics and also training for health visitors in developmental screening techniques.

6. Developmental screening of *all* children at 6 weeks, 1 year, and 2 years, by medical officers, and at 6 months and 18 months by health visitors should be the aim for the future.

7. It is desirable that the senior medical officer in the Health Department, in charge of the care of the pre-school handicapped, should form a close liaison with the local general practitioners and paediatrician with time for case discussion. She should be the clinical co-ordinator at the interfaces of change in the follow-up of the child.

8. More time is required to be allotted for searching out and assessing delayed children, so that we do not sit and wait for them to turn up at the Unit. The summary cards of the handicapped children should be perused and surveyed at regular intervals. Periodic reports should be requested from health visitors and Departmental medical officers so that the assessment, progress, and follow-up of each child is adequate. At present there are, at the end of 1970, 104 known children requiring regular assessment and follow-up. This is not possible due to pressure of other duties.

9. Full assessment well before 5 years should be our goal, so that his needs are known and can be catered for.

10. It is desirable to have also a senior medical officer in charge of school children and their needs, and a close link between her and the pre-school medical officer is essential for the effective care of the handicapped child.

CHILD AND FAMILY PSYCHIATRIC SERVICE.

This service continued to try to meet the demands upon it by the general practitioners and the schools. It will be seen from the tables that the number of children referred increased during the year, and that there was a very considerable addition to the number of interviews by the members of the clinic teams. There were changes among the staff ; Dr. Gabriel, who had been the psychiatrist at the Stevenage clinic since it started some 10 years previously, resigned in April and Dr. McGlashan, the psychiatrist at Watford and Hemel Hempstead, left in September on a year's leave of absence. There were also changes among the psychotherapists and the psychiatric social workers.

Dr. Roper, who had been attending at Hitchin and Welwyn Garden City, transferred to Stevenage from the Garden City clinic, and the county was fortunate in obtaining the services of Dr. Weston as a locum at Welwyn Garden City and Drs. Holman, Rappaport, and Anderson as locums at Hemel Hempstead and Watford. The North West Regional Hospital Board and the Tavistock Clinic agreed to joint appointments of registrars, both senior and junior, between the clinics at St. Albans and Watford and the Tavistock Clinic. With these additional staff and also more educational psychologists, an urgent need arose for more accommodation at many of these clinics in the county. Houses were being looked for in St. Albans, Watford, Bishop's Stortford, and Hitchin to meet the requirements of these clinics. The psychiatrists have kindly supplied the following reports.

Stevenage and Hitchin Clinics.

Dr. O. Roper, Consultant Psychiatrist :—

The Stevenage Clinic has seen a number of changes during the past year. Dr. Gabriel resigned in April after being 10 years in the clinic and the first psychiatrist to work there.

I moved from Welwyn Garden City so that Stevenage and Hitchin could be linked in the same area, with the New Lister Hospital as a common factor. There have been other staff changes—Mrs. Sonnenday, a social worker from America who had been working here for a year, returned to the United States in July. Mrs. Hall, who was a student of the Stevenage Social Workers' Course, joined us in September. We also welcomed Mr. Price who came to give some assistance to Mr. Sharma, the educational psychologist and divided his time between Stevenage and Hatfield.

In spite of these changes a great volume of work appears to have been dealt with at the clinic during the past year as well as the usual amount of time spent discussing problems with other agencies.

There has been considerable increase in the work at Hitchin during the past year, this is shown in the figures of new cases referred. What is not shown is the number of social work agencies whom we see at the clinic and to whom we act in a consultative capacity. These are sometimes in person and sometimes on the telephone.

The psychotherapist is now able to give us two days per week instead of one and this has been of valuable help to our work. A number of families have been taken on for regular treatment sessions and attendance has been remarkably good. Very few appointments appear not to have been kept.

This increase in work has put extra strain on our very limited accommodation and this remains one of our major problems. We have recently appointed a new social worker. The educational psychologist needs additional help but at present there is no accommodation available.

Welwyn Garden and Hatfield Clinics.

Dr. D. H. Weston, Consultant Psychiatrist :—

The number of new referrals has considerably increased this year with only a slight increase in the amount of psychiatric time available.

Mr. Price was appointed educational psychologist for the Hatfield area on 1st October, 1970, with four sessions per week. He also assumed responsibility for the Special Unit at Cranbourne Infants' School, previously the responsibility of Mrs. Gregory, educational psychologist for the Welwyn Garden City area. Mrs. Beck, student social worker at Stevenage College, has joined the clinic team at Gooseacre under the supervision of Mrs. Crouse, psychiatric social worker. In addition, Mrs. Mitchell, psychiatric social worker, has taken on three sessions—two sessions concerned with the School Psychological Service cases at both the Hatfield and Welwyn Garden City Clinics while in the other session she is working with families with children under five.

In view of these additions to the staff the physical drawbacks to both clinics referred to in Dr. Roper's previous report have become even worse. At the Queensway Health Centre the situation was particularly acute with no rooms allocated for clinic use. Play facilities were very limited and Mr. Price was forced to vacate his room during one of his sessions and no other room was available for his use. Secretarial help based at Hatfield was urgently required. At the moment Hatfield files are kept at Gooseacre and this causes considerable inconvenience to the professional staff who may require immediate access both to files and secretarial facilities when at Queensway Health Centre.

St. Albans and Boreham Wood Clinics.

Dr. R. L. Berstock, Medical Director :—

During the year the longstanding vacant posts for senior registrar, registrar, and senior psychiatric social worker, were filled and we were fortunate in obtaining an increase in secretarial staff at both clinics.

With the full complement of staff a more adequate service is now available. We have successfully maintained the waiting list to a minimum and an increasing number of children and families were attending for treatment. It was, however, considered that the more adequate a service offered, the more was the demand as shown by an increase of referrals and time spent in consultation with social agencies.

The advantages gained by filling the vacancies were obvious but this has accentuated the longstanding problem of inadequate accommodation both in room space and limited parking area allotted. This presents difficulties within the clinic and moreover hampers any consideration of extending our existing services.

During the year the clinic team have extended their contact with the teachers of the special schools, making visits to the schools and have invited members of the staff to the clinic to discuss their work with the clinic team. We hope next year to be able to extend this further to schools in general.

With the re-organization of the Health and Social Services it would appear to be essential to continue our consultative work with social agencies. However, I feel the clinic's main function should remain orientated towards the diagnostic assessment and treatment of the child and family. Thinking to the future, it seems evident that more special day facilities will have to be organized. Boarding school placement is not always the most appropriate or therapeutic recommendation for the individual child and even when it is, there are only a limited number of places at a particular time and as a result the waiting period is often prolonged. One project we could consider if we had the appropriate accommodation is to start a tutorial group for children who present with the

symptamatology of school phobia. It is hoped that in the near future alternate accommodation will be possible.

Watford Clinic.

Dr. E. Browne, Acting Medical Director :—

The clinic has continued in the house in Hempstead Road which gives a pleasant informal background particularly suited to a Child and Family Psychiatric Clinic.

In August, Dr. McGlashan went on leave of absence for a year and I, the other consultant psychiatrist already at the clinic, took over the Directorship in her absence. Two psychiatrists, Dr. Anderson and Dr. Rappaport came almost immediately to fill the empty sessions so the work continued almost without interruption.

In the Autumn the long promised senior registrar was appointed and was due to start in January, 1971. Permission to appoint a registrar was also given and the appointment should be made early in the New Year. This means some more psychiatric sessions but also that our clinic's association with the Department of Children and Parents of the Tavistock Clinic will be very close. A cross-fertilization will take place between a clinic which is internationally renowned for its pioneering in all fields of psychotherapeutic work and a local authority clinic with its day-to-day problems of having to provide a service as the need arises.

It has been of great help to the clinic that the vacancy for an educational psychologist has been filled by Miss Harrison who joined the team during the year.

Mrs. Hearst, senior caseworker, has continued to work with the Children's Department and is also taking part in group work with foster parents at the Children's Department.

We continued to train social work students from several colleges in intensive work which we considered to be a vital contribution to the future of the service.

Hemel Hempstead Clinic.

Dr. P. Holman, Acting Medical Director :—

New cases. The number has fallen very slightly. While the drop is hardly more than could be the result of a chance fluctuation, the more likely explanation is that it was due to lack of psychiatrists in September and October, from the time Dr. McGlashan went on a year's leave of absence until the time when Dr. Anderson and I came as temporary replacements towards the end of October. Even after that date, Dr. Anderson and I did not fully replace Dr. McGlashan and it is, I fear, inevitable that some aspects of the work of the Clinic will have less attention while Dr. McGlashan is away.

Total number of cases seen. The overall number of cases seen has gone up by nearly one-third, by comparison with last year.

Cases current at the end of the year. The number of cases current on 31st December, 1970, was 306. This was a fall on last year's figures, but can probably be explained by Dr. McGlashan's wish to conclude and close as many cases as possible before she left.

General. It is not easy for me to comment after so short a time here. The work is interesting and the standard of work of all members of the staff is very high.

May I venture to suggest, however, that the amount of time available to all sections of the staff is too limited and that shortage of accommodation leads to frustration and waste of the time of highly skilled workers.

Hoddesdon Clinic.

Dr. J. D. Waldman, Medical Director :—

Looking back to our contribution to last year's report the main area of change over 1970 would seem to have been in the matter of new staff. We have been joined by Mr. Goldberg, who is working as a therapist with us while completing his training at the Tavistock Clinic and also Dr. Anderson, whose two sessions a week as Consultant Psychiatrist are helping to relieve the volume of referrals. Miss Eeuwens has left us for the clinic in St. Albans and Miss King has joined us as senior psychiatric social worker.

Inevitably the convulsions in the Social Services have had their effect on us as well, but we have always worked well with the Social Services at field level and I am optimistic that co-operation will continue to be good.

A recent development of our co-operation with schools was the practice of varying contact with Heads and teachers on the telephone or at conferences in the clinic with visits of the clinic team to the schools themselves.

Bishop's Stortford Clinic.

Dr. J. Harris, Consultant Psychiatrist :—

I write this Annual Report with regret because I am leaving this clinic and am sorry to go. At the time of writing there has been no advertisement of the post here by the Regional Hospital Board although I gave notice in November, 1970, of my departure date. I have therefore been unable to make any plans other than to leave a treatment and follow-up waiting list. Miss Hutchinson, psychiatric social worker, fortunately will be here until the end of 1971 and is doing valuable work with the mothers of children on the treatment list, and Miss Black will continue to provide an invaluable link with the schools.

All of us feel, however, that the time has come for the clinic to expand both as regards available space and as regards the clinical time available here. It is a false economy not to provide early help and diagnosis—a false economy which this developing area cannot afford.

TABLE 50.—CHILD AND FAMILY PSYCHIATRIC CLINICS, 1970.

	Clinics.								
	North		Mid	St. Albans	South-West	Dacorum	East		Totals
	Hitchin	Stevenage	Welwyn Garden, Hatfield	St. Albans and Boreham Wood	Watford	Hemel Hempstead	Hoddesdon	Bishop's Stortford	
Current Cases as at 31.12.70 .	331	353	350	583	1,199	306	275	99	3,496
New cases referred during the year	144	129	169	186	216	109	111	75	1,139
Interviews									
Psychiatric and Psychotherapy	411	558	453	1,652	1,725	1,062	272	231	6,364
Psychiatric Social Worker .	612	569	765	2,098	3,826	2,546	1,030	299	11,745
Psychological and Remedial	71	624	391	167	846	428	206	101	2,834

SCHOOL PSYCHOLOGICAL SERVICE.

Miss E. M. John, Senior Educational Psychologist : —

During this last year a better staffing situation has been established than hitherto ; all 12 posts of educational psychologist were filled and there is the full complement of 14 remedial teachers. In these circumstances it has been possible to develop further some aspects of the service.

There has been an increase in the number of special classes, including two new junior units for children with severe language difficulties. Children with this particular handicap are likely to have long-term special educational needs and if local provision had not been made, the only alternative would have been placement at special boarding schools, if such places could be found. The co-operation of the speech therapists has made continued help possible. There were two special classes in secondary schools and it was hoped that these and other similar classes started in the future would serve the dual purpose of effectively helping the children, and of relieving the normal schools of the extra stress that these difficult children cause in a normal school setting.

The psychologists continued to make a contribution to in-service training in varied ways. Throughout the year there was participation in lecture courses and study groups at the Teachers' Centres, when the psychologists contributed one or two lectures in a varied programme. Some psychologists hold a regular weekly seminar for a small group of teachers and in these circumstances the subject is covered in depth ; this kind of contribution can only be offered to small numbers, but is more effective in its outcome than giving either a single lecture or a series of lectures to a large audience.

There was a week-end course at Offley on " Recent Advances in Psychology ", which was very well attended and the range of subjects included in the course was appreciated by the teachers ; indeed they seem to feel a strong need for further learning on a variety of psychological topics.

No. of interviews with children :	East Herts	S.W. Herts	St. Albans	Mid-Herts	Stevenage	North Herts	Dacorum	Totals
(*a*) Clinic	135	167	50	68	71	75	117	683
(*b*) S.P.S.	306	273	407	424	338	150	213	2,111
(*c*) J.T.C.	10	2	1	24	—	10	15	62
Interviews with parents	156	281	313	353	134	77	124	1,438
Professional consultations other than schools	158	698	653	947	84	421	181	3,142
School consultations	239	693	316	638	210	347	183	2,626
Lectures, seminars, discussion groups	29	95	48	66	11	27	31	307
(Therapy Sessions)			39	69				108
No. of new cases seen S.P.S.	186	205	171	231	294	149	66	1,302
No. of new cases referred S.P.S.	132	246	146	277	260	171	108	1,340
No. on waiting list	46	43	22	120	126	107	40	504
No. of units in area	3	3	3	4	5	4	6	28
No. of children in attendance at units	27	27	17	35	51	28	33	218
No. of children under remedial teaching	42	60	25	45	48	27	61	308
No. of boarding school visits	9	19	1	2	1	2	2	36

The transfer of responsibility for the education of the severely subnormal group of children has brought an extended range of work for the educational psychologists. During recent years the psychologists have been giving as much time as possible to work with children in the junior training centres but inevitably their experience with these children is limited, and their experience

with children in the subnormality hospitals has been almost non-existent. These new responsibilities are accepted with some anxiety but in so far as any extra training has been available, Hertfordshire psychologists have made use of it, and more important, have made contact with the clinical psychologists working in the local subnormality hospitals who, during a transition period, can be turned to for advice and guidance. There are significant opportunities in the future for the psychologists to help the teachers to promote the development and educability of these severely handicapped children and efforts will be made to advance this work.

HOLIDAY HOME CARE (CONVALESCENCE).

The number of school children requiring convalescence in any one year is comparatively small. During 1970, 38 were sent away, usually for 2–3 weeks to Homes mainly in Devon and Bournemouth. Several diabetic children had a short period in a camp run by the British Diabetic Association. In some instances, mothers accompanied their children to Homes which accepted a family group. The commonest cause for referral for convalescence was general debility where the home circumstances warranted a period of special care.

OTHER MEDICAL EXAMINATIONS.

(1) Entrants to Teacher Colleges of Education.

Local Education Authorities are required to arrange for the medical examination of :—

(*a*) College of Education candidates resident in their areas, and

(*b*) persons entering the authority's employment as teachers, who had not taken a course under the Training of Teacher's Regulations, and have not received a medical examination.

During 1970, the school medical officers examined 1,032 College of Education candidates and 120 teachers in category (*b*). College of Education candidates are advised to have a chest X-ray before entering college. At the finish of their training they are also medically examined by the College Medical Officer and X-rayed.

(2) Employment of Children Bye-Laws.

Children in employment out of school hours come within the scope of these bye-laws and should be medically examined before starting work. In 1970 2,745 pupils were examined, two were reported to be unfit to undertake the employment proposed.

STATISTICAL TABLES FOR THE WHOLE COUNTY.

Medical Inspection and Treatment, 1970.

The official return to the Department of Education and Science for the year ended 31st December, 1970 was as follows :—

Number of pupils on registers of maintained Primary and Secondary Schools (including Nursery and Special Schools) in January, 1971 — 171,464

Part I.—Medical Inspection of Pupils attending Maintained Primary and Secondary Schools (including Nursery and Special Schools).

Table 51.—Periodic Medical Inspections.

Age Groups Inspected (by year of birth)	No. of Pupils Inspected	Physical Condition of Pupils Inspected	
		Satisfactory	Unsatisfactory
		No.	No.
(1)	(2)	(3)	(4)
1966 and later	1,002	1,000	2
1965	8,346	8,323	23
1964	5,582	5,570	12
1963	755	752	3
1962	871	868	3
1961	418	416	2
1960	303	301	2
1959	518	516	2
1958	497	494	3
1957	293	293	—
1956	464	464	—
1955 and earlier	372	367	5
Total	19,421	19,364	57

	Per cent.
Col. (3) total as a percentage of col. (2) total	99·71
Col. (4) total as a percentage of col. (2) total	0·29

Table 52.—Pupils found to require Treatment at Periodic Medical Inspections (excluding Dental Diseases and Infestation with Vermin).

Age Groups Inspected (by year of birth) (1)	For defective vision (excluding squint) (2)	For any of the other conditions recorded in Part II (3)	Total individual pupils (4)
1966 and later	9	73	75
1965	299	1,088	1,262
1964	116	663	706
1963	22	59	69
1962	21	50	66
1961	15	45	57
1960	13	26	34
1959	29	32	57
1958	40	62	85
1957	26	28	44
1956	32	59	87
1955 and earlier	40	47	77
Total	662	2,232	2,619

Table 53.—Other Inspections.

Notes: A special inspection is one that is carried out at the special request of a parent, doctor, nurse, teacher, or other person.

A re-inspection is an inspection arising out of one of the periodic medical inspections or out of a special inspection.

Number of Special Inspections	4,672
Number of Re-inspections	14,828
Total	19,500

Table 54.—Infestation with Vermin.

(*a*) Total number of individual examinations of pupils in schools by school nurses or other authorized persons	188,955
(*b*) Total number of individual pupils found to be infested	322
(*c*) Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944)	126
(*d*) Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944)	4

Part II.—Defects found by Medical Inspection during the Year.

Table 55.—Periodic Inspections.

Note: All defects, including defects of pupils at nursery and special schools, noted at periodic medical inspections should be included in this Table, whether or not they were under treatment or observation at the time of the inspection. This table should include separately the number of pupils found to require treatment (T) and the number of pupils found to require observation (O).

Defect Code No.	Defect or Disease	Periodic Inspections							
		Entrants		Leavers		Others		Total	
		T	O	T	O	T	O	T	O
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
4	Skin	247	396	34	25	57	77	338	498
5	Eyes—								
	(*a*) Vision	424	316	71	22	167	114	662	452
	(*b*) Squint	288	150	7	2	44	21	339	173
	(*c*) Other	30	73	1	—	2	14	33	87
6	Ears—								
	(*a*) Hearing	219	682	4	9	41	56	264	747
	(*b*) Otitis Media	105	697	—	3	5	39	110	739
	(*c*) Other	13	79	—	1	2	4	15	84
7	Nose and Throat	200	1,473	10	4	38	115	248	1,562
8	Speech	207	602	3	—	18	38	228	640
9	Lymphatic Glands	15	562	2	1	4	53	21	616
10	Heart	35	341	1	5	9	36	45	382
11	Lungs	115	640	3	2	18	64	136	707
12	Developmental—								
	(*a*) Hernia	29	58	—	—	1	8	30	66
	(*b*) Other	61	250	3	10	12	59	76	419
13	Orthopaedic—								
	(*a*) Posture	15	64	3	11	5	26	23	101
	(*b*) Feet	74	371	9	16	20	63	103	450
	(*c*) Other	50	277	4	19	11	58	65	354
14	Nervous System—								
	(*a*) Epilepsy	26	59	3	—	14	9	43	68
	(*b*) Other	14	167	4	7	6	21	24	195
15	Psychological—								
	(*a*) Development	57	534	5	2	12	83	74	619
	(*b*) Stability	87	810	4	16	16	122	107	948
16	Abdomen	45	148	2	8	7	34	54	190
17	Other	44	182	7	10	15	62	66	254

Table 56.—Special Inspections.

Note: All defects, including defects of pupils at nursery and special schools, noted at special medical inspections should be included in this Table, whether or not they were under treatment or observation at the time of the inspection.

Defect Code No. (1)	Defect or Disease (2)	Special Inspections	
		Pupils requiring Treatment (3)	Pupils requiring Observation (4)
4	Skin	39	42
5	Eyes—		
	(*a*) Vision	186	70
	(*b*) Squint	14	6
	(*c*) Other	9	9
6	Ears—		
	(*a*) Hearing	66	39
	(*b*) Otitis Media	4	23
	(*c*) Other	8	5
7	Nose and Throat	20	57
8	Speech	19	26
9	Lymphatic Gland	1	9
10	Heart	6	23
11	Lungs	24	47
12	Developmental—		
	(*a*) Hernia	—	—
	(*b*) Other	9	30
13	Orthopaedic—		
	(*a*) Posture	3	6
	(*b*) Feet	18	23
	(*c*) Other	26	26
14	Nervous System—		
	(*a*) Epilepsy	5	6
	(*b*) Other	30	18
15	Psychological—		
	(*a*) Development	43	67
	(*b*) Stability	31	58
16	Abdomen	7	11
17	Other	37	112

Part III.—Treatment of Pupils attending Maintained Primary and Secondary Schools (including Nursery and Special Schools).

Notes: This part of the return should be used to give the total numbers of :—

(i) Cases treated or under treatment during the year by members of the Authority's own staff ;

(ii) cases treated or under treatment during the year in the Authority's school clinics under National Health Service arrangements with the Regional Hospital Board ; and

(iii) cases known to the Authority to have been treated or under treatment elsewhere during the year.

Table 57.—Eye Diseases, Defective Vision, and Squint.

	Number of cases known to have been dealt with
External and other, excluding errors of refraction and squint	197
Errors of refraction (including squint)	5,752
Total	5,949
Number of pupils for whom spectacles were prescribed	2,223

Table 58.—Diseases and Defects of Ear, Nose, and Throat.

	Number of cases known to have been dealt with
Received operative treatment—	
(*a*) for diseases of the ear	72
(*b*) for adenoids and chronic tonsillitis	499
(*c*) for other nose and throat conditions	33
Received other forms of treatment	279
Total	883
Total number of pupils in schools who are known to have been provided with hearing aids—	
*(*a*) in 1970	53
(*b*) in previous years	314

* A pupil recorded under (*a*) above should not be recorded at (*b*) in respect of the supply of a hearing aid in a previous year.

Table 59.—Orthopaedic and Postural Defects.

	Number of cases known to have been treated
(*a*) Pupils treated at clinics or out-patients departments	172
(*b*) Pupils treated at school for postural defects	48
Total	220

Table 60.—Diseases of the Skin (Excluding Uncleanliness, for which see Table D of Part I).

	Number of cases known to have been treated
Ringworm—(*a*) Scalp	1
(*b*) Body	—
Scabies	4
Impetigo	4
Other skin diseases	4,392
Total	4,401

Table 61.—Child Guidance Treatment.

	Number of cases known to have been treated
Pupils treated at Child Guidance clinics . . .	1,139

Table 62.—Speech Therapy.

	Number of cases known to have been treated
Pupils treated by Speech Therapists	1,983

Table 63.—Other Treatment Given.

				Number of cases known to have been dealt with
(*a*) Pupils with minor ailments				2,952
(*b*) Pupils who received convalescent treatment under School Health Service arrangements . . .				24
(*c*) Pupils who received B.C.G. vaccination . . .				9,269
(*d*) Other than (*a*), (*b*) and (*c*) above. Please specify :				
Abdomen . .	25	Heart . .	91	
Lungs . . .	131	Asthma .	41	
Epilepsy . .	26	Other .	806	
Appendicitis . .	54			1,174
Total (*a*)–(*d*)				13,419

PART V—REPORTS FROM DIVISIONAL MEDICAL OFFICERS.

Report of Dr. John Earle, Divisional Medical Officer, East Herts Division.

Dr. Gordon M. Frizelle, Divisional Medical Officer, East Herts Division, and Medical Officer of Health, East Herts Combined Districts, retired in October, 1970. Dr. Frizelle had a long, varied, and extremely valuable career in Public Health. After his retirement he was widely missed, both for his professional advice and for his personal friendship.

Dr. John Earle was appointed Acting Divisional Medical Officer, East Herts Division, and Medical Officer of Health, East Herts Combined Districts.

Miss E. Worster left her position as Divisional Nursing Officer, and Mrs. M. E. James took over her duties. Miss J. M. Beaumont was appointed as her Deputy.

Buntingford Health Centre.

Buntingford Health Centre and Group Practice Surgeries, White Hart Close, Buntingford, was officially opened on Wednesday, 21st October, 1970.

This new building has provided the physical structure where general practitioners and Local Health Authority staff can work in close professional contact. Easy access enables them to discuss their problems and make the best use of their various skills for the benefit of patients.

The architecture is excellent, which makes the building a pleasant place to work in. This is a simple but very important point in planning for medical care, as regards doctors, their helpers, and their patients.

Co-operation Between Branches of the Medical Services.

The county has arranged for departmental medical officers to attend courses to develop professional skills. Many of these courses are selected by the doctors themselves. They are important steps in post-graduate education and also, I believe, the hospital doctors who run the courses get an insight into modern public health during the informal discussions that often take place.

In the Hoddesdon area a group of general practitioners meet regularly for talks and discussions with hospital consultants. As a medical officer in Department and later as Acting Divisional Medical Officer I have attended these regularly. These informal meetings have done much to ease communications between these doctors and the Public Health Department.

A health visitor normally attends the weekly paediatrician's Out-patient Clinic at Hertford Hospital. He does a monthly Assessment Clinic at the Hoddesdon Health Centre. Many people, including departmental medical officers, health visitors, and educational psychologists, who are concerned with the care of individual children, often attend, and thus the Clinic may become a conference. It is only fair to say, however, that the time available for discussion is often limited, for the paediatrician has a heavy work load.

Venereal Disease.

Contact Tracing for V.D.

There is one health visitor in the Bishop's Stortford area who is engaged in contact tracing as part of her duties. If patients in this Division need treatment it seems likely that they may prefer to attend hospitals in London.

Health Education Against V.D.

It is widely but not universally accepted, that the general public—particularly young people—should know more about venereal disease. However,

when one comes down to the practical details of who should educate who, at what time, in what manner and in what place, there are many opinions. The increase of gonorrhoea makes this an urgent problem, but at the same time one must not rush towards any solution. It must be the best possible solution in the circumstances. Dull talks close minds. I think we should aim at a state of alert understanding, comparable to the understanding of other subjects.

Report of Dr. R. S. Hynd, Divisional Medical Officer, Dacorum Division.

CO-OPERATION WITH HOSPITAL AND FAMILY DOCTOR SERVICES.

(*a*) *Hospitals.*

For long there has been an exchange of information and views between the hospitals and the health department and particularly with the hospital departments of geriatrics and paediatrics where, obviously, there is much of common interest.

The link with the local geriatric department was forged some 12 years ago with a weekly meeting at the hospital of the geriatric consultant and his medical social worker with the divisional nursing officer. For the past 3 years the divisional welfare officer or his deputy has attended these meetings and the home help organizer has arranged similar meetings with the geriatric medical social worker.

From these meetings comes a constant flow of information about the patient's health, his home background, his probable length of stay in hospital, and finally the likely date of his discharge. This information is of use to the hospital in that it provides a clear picture of the patient's home background with any housing difficulties there may be and the difficulties there may be in providing community help, either from official or voluntary services including relatives. The local health authority equally benefits from knowing the probable length of stay and the likely date of the patient's discharge from hospital. With this knowledge the authority is better able to supervise the home conditions in the patient's absence, to keep up, where possible, the continued interest of nearby relatives in the patient's health and welfare and to organize, in advance, the nursing attention and home help assistance which is likely to be needed by the patient on his return home.

A similar linkage exists with the local paediatric department, though the linkage relates perhaps more closely to the clinical than the social aspects. Nevertheless consultant opinion is given on social matters such as educational requirements and the provision of school transport. The health department doctors and nurses attend, on a rota basis, the weekly paediatric out-patient clinics both to receive information and to gain clinical experience and training. Information so received is invariably acted upon, with the information being passed to colleagues where appropriate. In addition a copy of each letter sent by the consultant to the family doctor is also sent to the health department. A file on each child admitted to hospital or attending an out-patient clinic can thus be readily compiled.

Finally there is a constant flow of requests from the hospital medical social workers for domiciliary nursing attention, home helps, recuperative holidays, housing, etc., for discharged patients. All in all it is most unlikely in an atmosphere of such personal contact between hospital and health department staff that each does not know what the other has to offer.

(*b*) *Family doctor services.*

The relationship with the family doctors is, from the nursing angle, largely the history of the attachment schemes.

Attachment schemes for health visitors began with a pilot scheme in a selected practice some 10 years ago, to be followed in the next year with an attachment scheme for all general practices in the largest town of the division

and then a little more slowly throughout the remaining practices in the division. An attachment scheme for district nurses and midwives began 7 to 8 years ago and was complete throughout the division some 3 to 4 years later.

Recently a survey was undertaken to obtain an up-to-date picture of the individual practice arrangements with each nurse and the result showed a wide variety of arrangements even with individual doctors in the same practice and, importantly, a marked general improvement in attachment schemes in recent years.

A few practices have almost attained the perfect linkage with doctors and nurses working in complete harmony and understanding in well-baby clinics, cytology clinics, geriatric clinics, ante-natal and post-natal clinics, and minor ailment clinics with the health visitor doing home visits for the doctor, particularly among the young and the aged, advising and generally acting as a screen for the doctor by reporting in detail their medico-social findings. Contact in these practices is daily, for surgeries are sufficiently large to permit separate rooms for the nurses for counselling and minor treatments and dressings.

Most of the practices fall somewhat short of this ideal, with fewer clinics and less personal contact, but even here the will to co-operate is evident and it is usually the shortage of surgery space which prevents further advancement.

A very few practices show a disinclination to get on terms with the attachment schemes, there is no ill-will on either side, but a lack of interest and drive.

It would appear that the furtherance of practice attachment schemes depend largely on two main factors, the physical one of surgery accommodation and the personal one of the professional relationship between doctor and nurse.

Survey accommodation is improving but generally it has a long way to go before premises can be made large enough to accommodate both doctors and nurses. Personal relationship is obviously a more abstract matter, but the difficulty rests largely upon the difficulty of matching by temperament and attitudes the doctors and nurses. For all future nursing appointments it is essential that the family doctor is invited to attend the selection so that both know from the beginning what each other is like. The family doctor, as the leader of the team, should have the choice of his nursing partner if attachment schemes are to prosper.

Finally, in the terms of midwifery alone, attachment schemes are becoming no longer viable or even indicated. The trend towards domiciliary midwifery grows less, as either the provision of maternity beds increases and/or the early discharge of patients becomes more prevalent. Yet the local authority, largely because of easy housing accommodation with a subsidized rental, continues to attract midwives from badly staffed maternity wards only to employ them mainly on general nursing duties. It is a fact that most midwives are trained on appointment or afterwards in district nursing and employed in this duty for about 75 per cent of their time. The need to rationalize the midwifery services under the umbrella of one authority is patently obvious and steps should be taken to do this before and not after the inception of the area health authorities.

Venereal Diseases.

Before a campaign can be mounted against any particular disease its prevalence must be known with reasonable accuracy. A campaign without statistical support for the message it means to convey is a campaign lost from the start. The prevalence of venereal disease in a specific locality is notoriously difficult to obtain for it is not usually available from the records kept by the special clinics.

In this division local sufferers or suspected sufferers from venereal diseases must travel to Watford, St. Albans, or Aylesbury, or farther afield if they so wish, for clinic facilities. Clinics, in general, do not usually record their patients in districts and their catchment areas are commonly without defined boundaries.

Without these necessary statistics from the clinics the medical officer of

health is without information on the true picture of the venereal disease scene in his area. The community as a whole shies away from the unpleasant and bitterly resents any campaign which presents the national picture as that which equally applies locally without a shadow of statistical proof to support it. The community also resents wide-spread publicity on venereal diseases as a slur upon public morals. Indeed the most publicity that can usually be given is to display in the public conveniences the clinic facilities in nearby towns, the location of the clinic, and the times of attendance.

Possibly the only groups receptive to information on venereal diseases are senior school students and students in the local colleges. Any campaign in this age range must have the full support and participation of the education authority and the teachers and is probably better given in discussion groups in conjunction with similarly related subjects such as sex, drugs, smoking, and indeed any subject which could reasonably come under the general heading of " Life and the art of Living ". It is an idea which has not, as yet, been attempted here but maybe, now the division has a full-time health education officer, it might well be in the future.

Report of Dr. W. Norman-Taylor, Divisional Medical Officer, St. Albans Division.

The following are some of the more important or interesting aspects of our work in the division during the year.

Liaison with Hospitals and General Practitioners.

Although the attachment scheme has brought us into a much closer working relationship with general practitioners, liaison with hospitals is still not as close as we would like. At our local general hospital the medical social workers collaborate fully with the home help service and the district nursing service, but it is sometimes felt that these social workers themselves are not always kept fully in the picture by some of the hospital medical staff. The situation is even more difficult with London hospitals to which a considerable proportion of local patients are sent. This generalization does not apply to geriatrics and paediatrics, though here again one has the impression that some of the London hospitals are not always clear as to where our services can assist. In mental health, it can be stated that we enjoy very close co-operation, both with the psychiatric hospital and with the subnormality hospital. The two hostels run by the county in this division for the latter type of patient are very much linked with the hospital, and the consultant-in-charge (who is also the county's honorary adviser on subnormality) attends personally, or sends a representative to, all admission panel meetings. Indeed these hostels can be regarded as very much a part of the extension, into the community, of the rehabilitation role of the hospital, and, as such are a great success. Not a little of this success is due to the fact that we can rely on this consultant to readmit cases at once where any difficulty arises.

Health Education.

Health education should be a natural and integral part of all who work in the health department, particularly those in contact with parents and children. This applies not only to the medical officers and nurses but also to other staff who meet members of the public in a face-to-face situation. Medical officers have the added duty of trying to ensure that the school children in their care are not only " fit " but are equipped with the attitudes, skills, and knowledge of health habits appropriate to their age. Their success in this is dependent on co-operation with teachers, and in this respect teachers (and medical officers) differ. One of the medical officers, together with the school nurse, has developed a very

good working relationship in one particular secondary school. This medical officer reports as follows :—

" Every week, following a slightly attenuated school medical, we have been meeting groups of 10 to 20 boys from either the 4th or 6th forms. These go very well. The 6th-form discussions in particular are totally informal and take place in the 6th-form common room. We leave the choice of subjects discussed, but hope to steer the conversation towards such things as illegitimacy, contraception, etc., and try to bring in the subject of venereal disease if we can. We sometimes talk about drugs and smoking but the subjects vary. We only have one hour. The sessions appeared to be helpful and we usually leave a few of the pamphlets on V.D. and sex information for them to read if they are wanted. The 4th-form groups take place in a classroom which we re-arrange to make as informal as possible. These youngsters have already had a good deal of discussion on these subjects in a programme prepared by one of the masters. We were invited to deal specifically with medical questions handed in by the children. These include just about every question you can think of, including sex and drugs. It is often difficult to cover all aspects in one hour but we do our best. It is not so easy to get the children talking with so much factual work to be got through. The children have rated it successful though we felt we could do with even smaller groups and much more often."

Several of the medical officers have taken part in lecture/discussions at parents meetings, and are especially valuable on such subjects as sex and drugs.

We continue to receive direct help from one of the health education officers of the health education section of the county council who is attached virtually whole-time to the Division. This officer undertakes all the background " spade-work " of arranging meetings, hiring films well in advance, and generally supplying labour and hardware where needed.

One " campaign " was organized during the year, on the theme " Return of Unused Medicines " in support of the nation-wide RoSPA campaign on this subject. Built into the plan was an effort to evaluate the effect of this on the public and the results of this are awaited.

Drug Dependence.

There has been a change of emphasis in the approach to this problem during the year. It was felt that the Co-ordinating Committee, though very useful in respect of its co-ordinating function, was not suitable as an actual instrument for reducing the incidence of drug abuse. In particular it might at times appear too remote from the problem, and its " authoritarian " image could actually be a hindrance. Accordingly it was decided that some attempt at working closer to the community at risk should be made. One such venture was a series of discussion groups, attended by members of the Committee in an " off-duty " role, which were held at the Alma Road Youth Centre. These are proving most instructive, certainly for committee members, and, it is to be hoped, for the young persons attending. Health education in schools on this subject is also continuing. Following the B.M.A. concern that drugs are being " pushed " in schools, medical officers have been asked to warn school children particularly on this point.

Developmental Assessment.

In recent years it has been increasingly clear that our duties with regard to the surveillance of the health of the child population should be put on a more systematic footing, and the term " development assessment " has been coming increasingly into use. This term embraces two basic concepts : (1) a routine " screening " of *all* children at regular intervals by medical officers and health

visitors specially trained in this work, with a view to picking out potentially handicapped children, and (2) the regular assessment of the status and future needs of such children with a view to informed and rational forward planning. Progress in this field has necessitated a considerable amount of re-training, both at an in-service level and on special outside courses. In this division we were fortunate in being able to send one officer, Dr. Janet Hughes, on a course at the Wolfson Centre, Hammersmith, lasting the academic year ending in July. On her return we were able to arrange for her to be attached as clinical assistant to the consultant paediatrician at St. Albans City Hospital.

One of the first priorities, Dr. Hughes felt, was to emphasize to health visitors that development testing gave them, and the doctor, an improved clinical tool. This has encouraged a new orientation and attitude and is not viewed simply as yet another increase in the existing heavy work load. Six re-training sessions were arranged with health visitors in this division by Dr. Hughes. These were conducted in small groups, working on babies of 6 weeks, 6 months, and 10 months, and were used to demonstrate the significant aspects of development in the first year and the value of early recognition of deviant signs.

An essential part of the programme was the setting up of the assessment clinic within the paediatric department of the St. Albans City Hospital. The clinic is held once a week. Dr. Hughes reports as follows :—

"For a trial period it was decided that any child already attending the paediatric department, or known to the consultant, may be referred to the assessment clinic. At present these are usually children between 18 months and 3½ years who may have a handicap or show evidence of deviant development. One new child is seen per session. Before they attend their health visitor visits to explain the nature of the appointment and complete as far as possible a preliminary questionnaire. The family doctor is also invited to contribute any comment, and of course all existing hospital records are available for preliminary perusal. The child may be observed and examined without pressure of time and there is opportunity for long discussion with the parents who may reveal considerable anxieties and unburden at length. Following the session a comprehensive summary is distributed to hospital notes, divisional office handicap file, assessment file, general practitioner, and health visitor and clinic doctor (if the child is known to them).

These sessions have proved invaluable from the clinical management point of view and greatly appreciated by parents who realize with relief the time afforded to the total problem and planning of future help."

Venereal Disease.

The numbers attending the special clinic at the St. Albans City Hospital are relatively small. In 1970, there was 1 new case of syphilis, 86 new cases of gonorrhoea, and 322 other new attendances. The corresponding figures for 1969 are 4, 62, and 239 respectively. Contact slips are issued where appropriate. In St. Albans City for example, during the year 38 contact slips for gonorrhoea were issued and 24 of the persons contacted attended as a result. Figures for the rest of the division are not very relevant as many cases and/or contacts go either to Luton or to London. It is felt, however, that our contact tracing system is working well.

Report of Dr. G. R. Taylor, Divisional Medical Officer, Mid Herts Division.

With few changes in the staff and the gradual building up of the social work team the development and extension of the community health and social services in Mid Hertfordshire was well maintained throughout the year.

Developmental Screening.

The increased attention given to the developmental testing of young children by departmental medical officers, has resulted in more referrals to specialized clinics, e.g. audiology and speech therapy, the paediatricians, and child care officers and there is no doubt of the benefits to these selected children from earlier detection and the closer follow-up of abnormalities. While Dr. Powe and Dr. Jennings are particularly interested in the infant and very young child seen at the Infant Welfare Centre, Dr. Rigby is showing special interest in the young school child with specific learning disability. The child with a specific learning disability and a low average to E.S.N. level of intelligence will probably be placed in an E.S.N. school where, as a member of a small class and with fairly individual attention, he will obtain the opportunity he would not otherwise have had. The child of average to high intelligence, however, can expect at the best, one or two remedial reading or writing sessions per week so it is not surprising that some children of high potential, but with a limiting disability, make poor progress and later tend to show disturbed relationships. A closer link is developing with the Social Work Team to ensure that handicapped children of all categories are provided with the special chairs, eating utensils, and training equipment they need in the home, and that parents are fully advised on their use.

Immunization Campaign.

The general decline in the incidence of infectious disease among children in recent years, testifies to the effectiveness of the immunization campaign against poliomyelitis, smallpox, diphtheria, whooping cough, tetanus, measles, and tuberculosis. There has been a good response from parents to the introduction during the year of rubella vaccination of 13-year-old girls to remove the risk of acquiring infection occurring later during the early weeks of pregnancy and causing foetal abnormalities. The resurgence of measles throughout the winter of 1969–70 however, serves as a reminder of the need to attain a higher level of primary protection against this disease among susceptible children when entering nursery or primary school at 3–6 years of age, and the short outbreak of Asian type influenza during the first 2 weeks of the year also reminds us that we have not succeeded in finding effective means of eliminating recurring epidemics of this disease among the general population.

District Nursing Work.

During 1970 work undertaken in the district nursing service showed an overall increase as shown by the following details :—

District Nursing.	*1970.*	*1969.*	*Increase, %*
No. of medical cases	1,735	1,542	12·5
No. of visits	40,604	34,224	18·6
No. of surgical cases	638	373	70·5
No. of visits	10,338	8,891	16·0
Total no. of visits	52,050	43,693	19·0
No. of treatments in doctor's surgeries.	4,739	3,032	56·0
Included in the above :—			
Dressings	1,382	634	118·0
Injections	2,233	1,499	48·0
Treatment of ears	827	717	15·0
Special sessions attended	95	—	—

The increase in the number of surgical cases marks the first full year since arrangements were made with Mr. Cassie, Surgeon at the Queen Elizabeth II Hospital, for the early post operative discharge of patients from the hospital to the care of their general practitioners. With the agreement of the County

Medical Officer, arrangements were made for pre-sterilized dressing packs to be available to nursing staff for use in any case, while waiting for a supply to be obtained on prescription. The demand for these, although constant, is quite small. We have in fact encountered no practical difficulties in the implementation of this scheme.

In July, 1970, with the agreement of the general practitioners in the division, arrangements were made for requests for the nursing care of patients discharged from hospital to be received by their receptionists, for transmission to the district nursing staff attached to the practices. This change in procedure was accomplished very smoothly. The arrangements have worked well, and have resulted in a closer liaison between the general practitioner and the local authority health services, which has been of benefit both to the patients and to those concerned with their care. It is expected that enquiries concerning special problems relating to the nursing care of patients to be discharged from hospital and requests for special items of nursing equipment will continue to be directed to the divisional nursing officer, and it is known that the divisional health office staff are available to take and pass on messages to nursing staff if any difficulty should arise. There was also a marked increase in the work done in doctors surgeries, partly due to the opening of purpose built surgery premises by a further two group practices in March and October, 1970. In addition 95 special sessions were attended in doctors surgeries. These included family planning and obesity clinics.

Day Centre for the Elderly, Welwyn Garden City.

Following a recommendation to the Welwyn Garden City Old Peoples Welfare Committee by the divisional social worker, a day centre for infirm elderly people who are not members of the social clubs in the town was set up in April, 1970. The centre is run under the auspices of an organizing committee which is a permanent committee of the Old Peoples Welfare Committee, the daily programme consisting of a hot drink on arrival, about an hour's activity under the supervision of a voluntary physiotherapist, lunch followed by a programme of social and recreational activity in the afternoon with a cup of tea before departure. The club, with a membership of 16, meets on Wednesday of each week in the hall of the Free Church, transport being provided by the W.R.V.S. mini-bus.

In addition to the above club there has been an extension of group social work schemes for the elderly and handicapped throughout the division under the guidance of Miss Sturton. Special mention should be made of the group for blind and partially sighted clients in Welwyn Garden City, a group at Hatfield for housewives with emotional problems and an evening activity group for former drug users also in Hatfield. The support and practical help given by the churches and voluntary societies has been of great assistance to the social workers in forming these groups.

Drug Taking in Mid Hertfordshire.

While there was no major extension of the drug problem in Mid Hertfordshire during the year, experimentation and misuse of a wide variety of drugs continued to be prevalent particularly in the South Hatfield and Welham Green areas. It is to be expected that the local scene will reflect the situation in the central London area for it depends largely upon the availability of drugs there, but it is disturbing to know that the county police department still regard Mid Herts as a continuing endemic area for drug taking with many direct links with drug taking groups in the provinces.

Earlier in the year there was public concern in Hatfield at the activities of a group of young men seen to be injecting themselves with drugs in White Lion Square and public lavatories in the centre of the town, particularly at the

harmful effects of this public display of drug taking upon children and other young persons. Enquiry showed that the members of the group were mainly young men registered at the local addiction centre in Welwyn Garden City who were issued with their supply of physeptone at the chemist in White Lion Square, and so an attempt was made to provide facilities for the injection of the drugs in a room on the ground floor of the nearby Queensway Health Centre. Unfortunately the ebullient behaviour of the group soon showed that it is not advisable for such a service to be provided at the ordinary Health Centre although the room was not seriously misused or left in an untidy state. The use of alternative premises near the Town Centre, where facilities required could be provided independently of the other Health Centre activities, and yet still under supervision, was considered to be necessary but within a few weeks the problem solved itself as the number of young people injecting themselves rapidly declined and the public concern abated.

Throughout the year cannabis smoking, mainly at weekends by groups of young people, was reported from time to time, but heroin and the more serious forms of addictive drugs remained in scarce supply, although tending to become more readily available in the London area at the end of the year. Experimenting with LSD led to acute mental upset in two young men. In South Hatfield and Welham Green a few suspected drug takers exerted a baneful influence on school children aged 14–16, particularly young girls about to leave school. The staffs of all Secondary Schools in the area were notified of these dangers and advised to warn their senior pupils of the risk incurred in associating with cannabis smoking or drug taking groups.

Following the circular letter from the British Medical Association to all members in the Autumn recommending a voluntary ban on the prescribing of amphetamines and barbiturate preparations to persons under 25 years of age the matter was discussed at local meetings. Although total agreement to such a voluntary ban was not acceptable to some practitioners, the majority expressed approval, and pharmacists reported a considerable reduction in the amounts of these drugs prescribed. The Committee were informed that the contents of pocket type inhalers had been modified to exclude amphetamines and while one member of the Liaison Committee expressed concern at the open sale of these inhalers at chemists shops, the pharmaceutical representatives reported no evidence of misuse or rise in sales.

The Queen Elizabeth II Hospital continued to play a major role in the investigation treatment and support of drug takers in the area in conjunction with the addiction clinic and the work of the social workers in the domiciliary field. The number of young persons admitted to hospital for treatment showed wide variation from month to month but declined from 6–8 in the summer to 3–4 by the end of the year. Attendances at the Addiction Clinic steadily declined over the year to a weekly average of 8 patients in varying stages of withdrawal from addictive drugs. While it is difficult to ensure that drug takers registered as attending the Welwyn Garden City Addiction Centre are not also attending treatment centres in the London area, it is obviously desirable for any registered addict for whom heroin is prescribed at a London treatment centre to obtain his supply of the drug from a chemist in the London area to reduce the risks arising from heroin again being dispensed in Mid Hertfordshire.

By the end of the year a group of eight former drug takers were in residence at Roe Hill House with regular staff meetings and group discussions to define more precisely the roles of the staff and advisers and the most effective means of providing support and gaining the interest and participation of the residents in projects and activities. The development of group activities has been delayed by staff changes but the Richmond Fellowship are hoping shortly to bring the staff up to full establishment so that the recommendations of the professional advisory group can be fully implemented. It is reassuring to know that the majority of the residents are maintaining full time employment in Hatfield and no major problems of management have arisen at the hostel.

The working party continues to be active in promoting publicity on the dangers of drug addiction particularly in assisting the Health and Welfare Department Staff in arranging talks and discussions in schools and also the occasional public meeting. Through its professional voluntary members a considerable number of personal consultations and interviews with former addicts are maintained providing much useful information on the problems and reactions of the young drug takers in the area, in conjunction with the work of the hospital and Local Authority staffs. The parents group continues to meet regularly encouraging parents to play their full part in providing support and understanding by the family of the young drug takers problems in the difficult period of adjustment to a more regular way of life.

Report of Dr. J. D. Hall, Divisional Medical Officer, North Herts.

As in the previous year, no major changes occurred in the Division during 1970.

Venereal Disease.

A health visitor was attached to the Special Clinic at the Lister Hospital, Hitchin, and attended twice weekly in order to carry out contact tracing. This has proved successful, and resulted in 4 males and 35 females being traced.

A meeting with local general practitioners was arranged at which films were shown by Dr. Cree the Venereologist.

Health Education.

In October, 1970, Mr. I. C. Fairfax, Health Education Officer, was appointed to the North Hertfordshire Division. Meetings and discussions were arranged with medical officers and health visitors in order to co-ordinate health education projects in the community to assist schools with health education. Arising from this a programme of talks to schools was drawn up with the co-operation of the school Heads on the subjects of drugs and venereal disease. This venture is continuing to expand with success.

Care of the Elderly.

A weekly geriatric referral meeting held at the Lister Hospital was attended by the divisional nursing officer throughout the year. Discussions took place with doctors, ward sisters, and therapists regarding patients in the hospital with particular reference to their needs after discharge. These meetings proved helpful in establishing follow-up nursing, medical loan, and general after-care.

Report of Dr. A. Shaw, Divisional Medical Officer, South West Herts Division.

Services for the Elderly.

Services for the elderly are developing rapidly although there are some marked gaps. The relatively healthy elderly are catered for to some extent by county council sponsored day centres, Darby and Joan clubs, and the like. In this division there has been a marked increase in the numbers of day centres operating for one day a week or more. The chiropody, district nursing, and meals-on-wheels services are used extensively and district councils are far-sightedly building special housing accommodation for the elderly, the most recent example being Storey Court in Bushey, which is nearing completion.

However, there are gaps, as I have mentioned earlier and the most obvious of these is in the provision for the elderly mentally confused. Such old people are often in a particularly pitiable condition and, equally important, their families must bear what is frequently an intolerable strain. It is recognized that

many mentally confused old people are not suitable for admission to old people's homes, especially if incontinence is a feature of their decay, nor would they benefit from the curative regime of the geriatric ward of a hospital, and often the only place they be can admitted is to a mental hospital, an alternative which most families reject decisively until the final breaking point.

Decay of mental facilities is an inevitable feature of the late years of many people but it is quite wrong to accept this supinely. If facilities were available for care and occupation during the day then the process of deterioration could be delayed and at the same time a large measure of relief offered to families. The South-West Hertfordshire Divisional Health and Welfare Executive recommended to the County Health and Welfare Committee last year that a site should be sought with a view to building such a centre.

In the care of such patients the hospital must also play its part and geriatric day hospital facilities must be developed hand in hand with local authority provision. To date there are no adequate day hospital facilities within the division, a state of affairs which both the geriatrician and I would like to see remedied as soon as possible.

Co-ordination and Co-operation with Hospital and Family Doctor Services.

For some years in this division there have been attachment of health visitors to all general medical practices. Over the past two years practices in Bushey, Central Watford, and Garston have made rooms available for health visitor district offices and this has worked to the benefit of the patient, the doctor, and the Health Department. It is a pleasure to hear doctors talking about " my health visitor "—a true indication that health visitors are now an integral part of general practice.

District nurses also are now all attached to general practice and not restricted to geographical areas. To counteract extra travel involved nurses hold their own " surgeries " at general practice premises and patients who can be treated at the surgery are treated there rather than at home. In the hospital field also a close liaison is developing between district nurses and hospital sisters and patients who can be discharged home earlier to a suitable home are so discharged. Not all homes are suitable however, nor are all relatives able to devote the necessary care to say, a chronic bronchitic who needs warmth, rest, nutrition and antibiotics to get over the acute illness. The same reasoning applies to early discharge of " cold surgery " patients, with the added complication that with an improved turnover of bed usage a number of hospitals might have difficulty in providing increased operating theatre time.

The opening of the general practitioner maternity unit at Shrodells Wing, Watford General Hospital has meant an improvement in the already good liaison between domiciliary midwives and general practitioners and has brought the domiciliary midwives into closer contact with their hospital colleagues. Our midwives deliver their own patients in hospital and this is very good for the patients in that she has continuity during pregnancy, delivery, and the puerperium. The number of G.P. beds is, however, too small to make an appreciable impact on the domiciliary midwifery service.

Venereal Diseases.

South-West Hertfordshire has shown the same order of rise in numbers of cases of venereal disease as the rest of the country.

Measures to prevent the disease and to stop the spread involve the dissemination of information to the general public by means of health education. Health education on venereal diseases in South-West Herts involves a close co-operation between the health department and the venereologist, who has lectured to staff. In addition, an in-service training session has been held at the

Teachers Centre, Tolpits Lane, and in this session venereal diseases were fully discussed. It is hoped that with the co-operation of the warden (Mr. Alan Wheatley) and the Divisional Adviser on In-Service Training for Teachers (Mr. G. F. Westaway) that further courses will be held.

In so far as school children are concerned, it is our belief that information on health matters should be part of the general education background and the aim is to inform teachers so that they are in a position to put the facts before children in a knowledgeable way. Health education leaflets and posters are freely available for school libraries and when requested members of health department staff will act as visiting speakers.

An assessment of the level of knowledge of venereal diseases in teachers is being made by questionnaires sent to certain teachers in secondary schools. This will assist in planning future in-service training.

South-West Hertfordshire is the only part of the county at present having an automated telephone answering device giving information on symptoms of venereal disease and treatment facilities. The telephone number is supported by poster publicity.

Two health visitors were attached to the special clinic at Shrodells hospital and assist with contact tracing. It is frequently the case that the female partner does not know she is suffering from the disease and if she can have treatment then further cases can be prevented. In this respect contact tracing is very valuable health education.

Recently the Health Education Council has issued a poster which states frankly the symptoms and signs of gonorrhoea. It is conceivable that such a poster could cause offence and public health committees of all five councils in South-West Herts were asked their views on public display. There was almost unanimous agreement that the poster should be displayed and arrangements were made to do this. In addition, the poster has been offered to technical colleges and factories in the division.

A crucial point in securing early attendance for treatment of venereal disease is getting the patient to realize that he or she could actually be suffering from the disease. The more information people have in this respect the better. The same reasoning applies to publicization of treatment facilities but the difficulty in this respect is vandalization of posters. Ceramic tiles which can be set into the walls of public conveniences would seem to offer a better alternative than posters, and quotations are being obtained from a firm specializing in this type of work. Four of the five councils in the area have agreed so far to bear the cost of the tiles and labour.

Spina Bifida.

Dr. F. Barasi, Deputy Divisional Medical Officer, acts as medical officer to Hangers Wood School for Physically Handicapped Children. A considerable body of knowledge has been built up on the management of such children and Dr. Barasi reports, *inter alia* :—

"There are at present 12 Spina Bifida children in Hangers Wood School, with the usual preponderance of girls, i.e., 8 girls to 4 boys. Special attention must be paid to bowel function, urinary problems, and skin care.

It is possible to underestimate the strain induced on the family in the care of a Spina Bifida child, particularly where there are a number of younger children, where mother's health is indifferent and where the husband is either away a good deal or unhelpful. The continuous care of a Spina Bifida child involves an increasing burden on the whole family—on the mother particularly with repeated out-patient and in-patient hospital treatment necessary.

As far as hospitals are concerned the team approach is constantly urged to the problem of Spina Bifidas yet this often appears to be notably lacking. Specialists appear rarely to consult as a team and almost never is the child seen

in out-patients by more than one of them at a time. Orthopaedic management rarely is expected to give more than a small improvement in these cildren's mobility. At this time it is not possible to be sure how many of our children are likely to become chairbound despite all the effort expended on calipers, hip operations to reinstate hip stability, and hours spent on physiotherapy.

Academically most of our children are of average intelligence, good verbally but initially show up less well in performance and are easily distractable. Again it is not possible at this stage to forecast which of these children will be able to manage in a secondary school in the future.

Many of the children look below par and never really well."